

**UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF RHODE ISLAND**

STATE OF COLORADO, et al.,

Plaintiffs,

v.

U.S. DEPARTMENT OF HEALTH AND
HUMAN SERVICES, et al.,

Defendants.

C.A. No.

DECLARATION OF TEESHA R. KIRSCHBAUM

I, Teesha R. Kirschbaum, declare as follows:

1. I am a resident of the State of Washington. I am over the age of 18 and have personal knowledge of all the facts stated herein, except to those matters stated upon information and belief; as to those matters, I believe them to be true. If called as a witness, I could and would testify competently to the matters set forth below.

2. I am currently employed by the Washington State Health Care Authority (HCA) as the Director of the Division of Behavioral Health and Recovery (DBHR).

3. The goals of DBHR are to support the delivery of a public behavioral health system that provides effective, accessible, and fiscally responsible mental health and addiction treatment as a public safety net.

4. As Director of DBHR, I am responsible for administering the publicly funded behavioral health system in Washington State as the Mental Health Commissioner and Substance use Disorder Single State Authority.

5. After the COVID pandemic placed an enormous strain on Washington's behavioral healthcare system, Congress took action to address this increased and currently ongoing need. The American Rescue Plan Act of 2021 (ARPA), signed by President Biden on March 11, 2021, directed the U.S. Department of Health and Human Services (HHS), Substance Abuse and Mental Health Services Administration (SAMHSA) to provide additional funds to support states through Block Grants to address the effects of the COVID -19 pandemic for Americans with mental illness and substance use disorders. ARPA allocated \$1.5 billion each for Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block (SABG) grants to the states. Congress allocated funding to the states to spend through September 30, 2025.

6. SAMHSA awarded HCA with four of these grants. However, on March 24, 2025, HCA received terminations for all four awards from SAMHSA—effective immediately. The total value of the remaining available fund balance of the terminated awards was over 30 million dollars. All terminations were based on the end of the COVID pandemic, rather than failure of the Division to follow the terms or conditions of the grants. Each award termination uses the same language stating,

The termination of this award is for cause. The block grant provisions at 42 U.S.C. §300x-55 permit termination if the state “has materially failed to comply with the agreements or other conditions required for the receipt of a grant under the program involved.” The end of the pandemic provides cause to terminate COVID-related grants and cooperative agreements. These grants and cooperative agreements were issued for a limited purpose: to ameliorate the effects of the pandemic. Now that the pandemic is over, the grants and cooperative agreements are no longer necessary as their limited purpose has run out.

Descriptions of each award and the effects of these terminations follow.

Substance Abuse Prevention and Treatment Block Grant

7. In 2021, SAMHSA invited applications for Substance Abuse Prevention and Treatment Block Grant (SABG) under the American Rescue Plan Act of 2021 (ARPA).

8. States are required to plan for, expend, and report on the FY 21 SABG ARPA Supplemental Funding based on 42 U.S.C. Chapter 6A, Subchapter XVII, Part B, Subpart II: Block Grants for Prevention and Treatment of Substance Abuse, and 45 CFR, Part 96, Subpart L.

9. As set out in its grant proposal, HCA intended to expend not less than twenty percent (20%) of their total allocation for substance use disorder primary prevention services for individuals who do not require treatment for substance abuse, in accordance with 42 USC 300x–22 and 45 CFR 96.124 and 96.125.

10. In 2021, HCA received notice of award (NOA) for the SABG in the amount of \$30,586,435 with an award period beginning September 1, 2021 and ending September 30, 2025. A true and correct copy of this notice is attached as Exhibit A.

11. In 2020, SAMHSA issued a document entitled “Certification and Assurances/Letter Designating Signatory Authority [SA],” setting forth the terms and conditions of the SABG grant award. A true and correct copy of this document is attached as Exhibit B. Neither the NOA nor the Certification and Assurances provided any process whereby HHS could unilaterally issue retroactive termination of an award already made to the State for use of these funds.

12. Since September 2021, HCA has used the SABG funds in a manner fully consistent with HHS’s statements regarding the nature of the grant and HCA’s grant application. This includes various evidence-based services and supports for individuals, families, and communities. Integral to the SABG are its efforts to support health equity through its priority focus on the provision of substance use disorder prevention, treatment, and recovery support services to identified underserved populations. These underserved and marginalized populations include, but are not limited to, pregnant women and women with dependent children; persons who inject drugs; persons using opioids and/or stimulant drugs associated with drug overdoses; persons at risk for HIV, TB, and Hepatitis; persons experiencing homelessness; persons involved in the justice system; persons involved in the child welfare system; Black, Indigenous, and People of Color (BIPOC); LGBTQ individuals; rural populations; Tribal Governments, and other underserved groups.

13. Nevertheless, on March 24, 2025, HCA received an email from SAMHSA, purporting to terminate the grant effective March 24, 2025. A true and correct copy of the grant award termination email is attached as Exhibit C. On March 28, 2025, HCA received another email

termination notice from SAMHSA. This notice “superseded” the prior notice but the effective date remained the same. A true and correct copy of the grant award termination email is attached as Exhibit D.

Block Grants for Community Mental Health Services

14. In 2021, SAMHSA invited applications for Community Mental Health Services Block Grants (MHBG) under the American Rescue Plan Act of 2021 (ARPA).

15. States must spend the MHBG funds based on 42 U.S.C. Chapter 6A, Subchapter XVII, Part B, Subpart I: Block Grants for Community Mental Health Services for adults with Serious Mental Illness and children with Serious Emotional Disturbances. The MHBG allocation requires states to set aside ten percent (10%) of their total allocation for first-episode psychosis or early serious mental illness programs.

16. As set out in its grant proposal, HCA intended to support community mental health services for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbances (SED). Focus on support of a behavioral health crisis continuum is encouraged. An effective statewide crisis system affords equal access to crisis supports that meet needs anytime, anyplace, and for anyone. This includes those living in remote areas and underserved communities as well as youth, older adults, persons of diverse backgrounds, and other marginalized populations; the crisis service continuum will need to be able to equally and adeptly serve everyone.

17. In 2021, HCA received notice of award (NOA) for the MHBG in the amount of \$33,202,279 with an award period beginning September 1, 2021 and ending September 30, 2025. A true and correct copy of this notice is attached as Exhibit E.

18. In 2020, SAMHSA issued a document entitled “Certification and Assurances/Letter Designating Signatory Authority [MH],” setting forth the terms and conditions of the MHBG grant

award. A true and correct copy of this document is attached as Exhibit F. Neither the NOA nor the Certification and Assurances provided any process whereby HHS could unilaterally issue retroactive termination of an award already made to the State for use of these funds.

19. Since September 2021, HCA has used the MHBG funds in a manner fully consistent with HHS's statements regarding the nature of the grant and HCA's grant application.

20. Nevertheless, on March 24, 2025, HCA received an email from SAMHSA, purporting to terminate the grant effective March 24, 2025. A true and correct copy of the grant award termination email is attached as Exhibit G. On March 28, 2025, HCA received another email termination notice from SAMHSA. This notice "superseded" the prior notice but the effective date remained the same. A true and correct copy of the grant award termination email is attached as Exhibit H.

Mental Health and Substance Abuse Block Grants–COVID Mitigation

21. In 2021, SAMHSA invited applications for SABG-COVID Mitigation and MHBG-COVID Mitigation under the American Rescue Plan Act of 2021 (ARPA).

22. As set out in its grant proposal, HCA intended to use the SABG-COVID Mitigation and MHBG-COVID Mitigation awards to address the following: People with mental illness and substance use disorder are more likely to have co-morbid physical health issues like diabetes, cardiovascular disease, and obesity. Such chronic illnesses are associated with higher instances of contracting COVID-19 as well as higher risk of death or a poor outcome from an episode of COVID-19. To address this concern, SAMHSA invested \$2,218,856 in Washington state to expand dedicated testing and mitigation resources for people with mental health and substance use disorders.

23. In 2021, HCA received notice of award (NOA) for the MHBG-COVID Mitigation in the amount of \$1,142,613 with an award period beginning September 1, 2021 and ending September 30, 2025. A true and correct copy of this notice is attached as Exhibit I. The terms and conditions for this award are set forth in Certification and Assurances attached as Exhibit F. Neither the NOA nor the Certification and Assurances provided any process whereby HHS could unilaterally issue retroactive termination of an award already made to the State for use of these funds.

24. In 2021, HCA also received the SABG-COVID Mitigation award, in the amount of \$1,076,243 with an award period beginning September 1, 2021, and ending September 30, 2025. A true and correct copy of this notice is attached as Exhibit J. The terms and conditions for this award are set forth in Exhibit B. Neither the NOA nor the Certification and Assurances provided any process whereby HHS could unilaterally issue retroactive termination of an award already made to the State for use of these funds.

25. Since September 2021, HCA has used the MHBG-COVID Mitigation and SABG-COVID Mitigation funds in a manner fully consistent with HHS's statements regarding the nature of the grant and HCA's grant application.

26. Nevertheless, on March 24, 2025, HCA received emails from SAMHSA, purporting to terminate these grant effective March 24, 2025. True and correct copies of these grant award termination emails are attached as Exhibits K and L. On March 28, 2025, HCA received additional email termination notices from SAMHSA. These notices "superseded" the prior notices but the effective date remained the same. A true and correct copy of these grant award termination emails are attached as Exhibit M and N.

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These Federal Funds Support Washington's Behavioral Healthcare System

27. The above federal awards fund our regional Behavioral Health Administrative Service Organizations (BH-ASO) through direct contracts with community behavioral health agencies and 16 federally recognized tribal governments in the state of Washington. This funding is supporting low-income non-Medicaid individuals with serious mental illnesses and substance use disorders, populations disproportionately impacted by the pandemic. While the funds were appropriated in direct federal response to COVID-19, it's important to note the grants support a broad range of providers and services intended to help some of Washington's most vulnerable populations.

28. HCA received the funding in 2021 and began contracting with our regional BH-ASOs and with a large volume of community behavioral health agencies to deliver behavioral health services with the funding from these awards. HCA has worked in partnership with these contractors to ensure funding is utilized to its fullest extent to meet unmet behavioral health needs of Washington's population that resulted from the COVID-19 pandemic.

29. The contracting impacts of the federal termination are significant because HCA's research has shown that this would impact approximately 200 contracts with subgrantees, many of which require that HCA give 15 days' notice for termination, yet SAMHSA has terminated the grants effective immediately. This is unprecedented.

The COVID Pandemic Created a Behavioral Health Crisis That is Far From Over

30. As a result of the COVID-19 pandemic Washington experienced an increased need for behavioral health crisis services to support individuals and families experiencing a behavioral health crisis. This need is ongoing. Funding supports 24/7 crisis hotlines that would be

called in a crisis, mobile crisis response teams that would provide outreach, and crisis stabilization services to support people as their crisis resolves and help them engage with ongoing care.

31. HCA utilized funding to prioritize meeting the behavioral health needs for low-income non-Medicaid individuals as they were destabilized financially from the COVID-19 pandemic to ensure they were able to access the outpatient fundamental behavioral health services to help meet those increased needs.

32. Children and youth experienced some of the highest behavioral health impacts from the COVID-19 pandemic and that need has not returned to the pre-pandemic baselines. HCA utilized this funding to support children, youth, and their families as they navigated new and continuing serious behavioral health challenges including ensuring prevention, school-based, and treatment services.

33. Substance use disorder increased significantly as a result of the COVID-19 pandemic. HCA used this funding for essential prevention support for community prevention and wellness initiatives to ensure healthier Washington communities. As well as services and support for people experiencing addiction, naloxone to prevent overdose, and recovery and housing to help people regain their lives.

These Terminations Cost Washington Over 30 Million in Behavioral Health Care Funds

34. As of March 24, 2025, Washington stands to lose over 30 million dollars in funds already obligated to provide behavioral health care services. SABG has a remaining committed balance of \$12,928,561.36, MHBG has a remaining committed balance of \$17,645,116.06, SABG-COVID Mitigation has a remaining committed balance of \$763,394.71 and MHBG-COVID Mitigation has a remaining committed balance of \$1,136,501.14.

35. Funding for these awards would have been used to provide payment for services provided for low income, non-Medicaid programs and treatment services for individuals with, or at risk of substance use disorder and individuals diagnosed with serious emotional disturbances or serious mental illness.

36. The next scheduled disbursement was set for April 9, 2025 for all four awards. Although the termination emails informed HCA that it would be able to draw funds for costs up to March 24, 2025, that has not been HCA's experience. Normally, upon initiating a draw from PMS, claims are processed within 24 hours and HCA receives funds. However, on March 24, 2025, HCA tried to draw funds for claims incurred prior to March 24, 2025. HCA has yet to receive these funds. Moreover, as of March 28, 2025, the federal payment system also appears to be locked for draws of all other mental health and substance use block grant funds that are separate from these particular grant awards.

37. As of March 28, 2025, HCA has not received further instructions on drawing funding for work prior to March 24, 2025, or further communication regarding the 90 day close out period requirements from SAMHSA. This has impaired HCA's ability to pay contractors on outstanding claims.

Loss of These Funds Harms HCA's Ability to Provide Services

38. HCA has consistently submitted deliverables on or before deadlines set by SAMHSA, provided quality and detailed applications, workplans and annual progress reports, and been responsive to and compliant with requests from SAMHSA. HCA has been considered a top performing agency and a leader in health care innovation and our dedication to supporting behavioral health services across the continuum of care for individuals most in need. Our SAMHSA Project Officers have thanked us for our "willingness to go above and beyond" and

have invited us to present at various meetings with other states as national leaders in the integration of behavioral health care. HCA has worked diligently to ensure we maintain a strong working relationship with our SAMHSA Project Officers and maintain open communication on a regular basis.

39. HCA relied and acted upon its expectation and understanding that HHS would fulfill its commitment to provide the funding it had awarded to HCA. This funding was planned to support critical services and positions in behavioral health treatment through September 2025, the abrupt loss of which will cause immediate staffing shortages, with no time to transition care for individuals receiving services or prepare workforce. Without the planned remaining six months of these awards to bridge the individuals receiving services and the workforce from this funding, these agencies may be forced to abruptly discontinue services and/or close their doors. Behavioral health agencies operate on a very small margin and an abrupt funding loss threatens their viability which impacts the entire behavioral health system. These effects would be magnified in rural areas with limited providers. This would destabilize the state behavioral health system, including the crisis system and deep end behavioral health supports that are essential to support the safety net needed to keep individuals in the state safe, healthy, and out of the criminal legal system.

40. With the loss of this funding the Washington behavioral health system will be destabilized, individuals and families will experience delays, service gaps, and/or the negative impacts of untreated behavioral health conditions. The abrupt loss of funding will have the greatest impact on individuals and families and will result in the inability to transition individuals from the care they are currently receiving. This may result in decreased functioning, relapse, hospitalization, arrest, and other adverse outcomes.

41. The award terminations have had ramifications for HCA's network of contracted behavioral healthcare sub-grantees and providers. HCA has had to provide notices to terminate services for approximately 200 sub-grantees and could incur the financial cost of these services. This also damages the HCA's relationships and other work underway with our small community providers and Tribal Governments who may lose trust in our funding sources for current or future efforts.

42. To this day, HHS SAMHSA has never provided HCA with notice, written or otherwise, that the grant administered by HCA was in any way unsatisfactory.

I declare under penalty of perjury under the laws of the United States that, to the best of my knowledge, the foregoing is true and correct.

Executed on March 28th, 2025, at Olympia, WA.



TEESHA KIRSCHBAUM, Director
Division of Behavioral Health and Recovery
Washington Health Care Authority

Exhibit A

**Recipient Information****1. Recipient Name**HEALTH CARE AUTHORITY
626 8TH AVENUE SE

OLYMPIA, WA 98501

2. Congressional District of Recipient

10

3. Payment System Identifier (ID)

1911412780A1

4. Employer Identification Number (EIN)

911412780

5. Data Universal Numbering System (DUNS)

007207571

6. Recipient's Unique Entity Identifier**7. Project Director or Principal Investigator**

[REDACTED]

[REDACTED]

8. Authorized Official

[REDACTED]

Federal Agency Information**9. Awarding Agency Contact Information**

[REDACTED]

Grants Management Specialist
Center for Substance Abuse Treatment

[REDACTED]

[REDACTED]

10. Program Official Contact Information

[REDACTED]

Center for Substance Abuse Treatment

[REDACTED]

Federal Award Information**11. Award Number**

1B08TI083977-01

12. Unique Federal Award Identification Number (FAIN)

B08TI083977

13. Statutory Authority

Subparts II&III,B,Title XIX,PHS Act/45 CFR Part96

14. Federal Award Project Title

Substance Abuse Prevention & Treatment Block Grant

15. Assistance Listing Number

93.959

16. Assistance Listing Program Title

Block Grants for Prevention and Treatment of Substance Abuse

17. Award Action Type

New Competing

18. Is the Award R&D?

No

Summary Federal Award Financial Information**19. Budget Period Start Date 09/01/2021 – End Date 09/30/2025****20. Total Amount of Federal Funds Obligated by this Action** \$30,586,435

20 a. Direct Cost Amount \$30,586,435

20 b. Indirect Cost Amount \$0

21. Authorized Carryover**22. Offset****23. Total Amount of Federal Funds Obligated this budget period** \$30,586,435**24. Total Approved Cost Sharing or Matching, where applicable** \$0**25. Total Federal and Non-Federal Approved this Budget Period** \$30,586,435**26. Project Period Start Date 09/01/2021 – End Date 09/30/2025****27. Total Amount of the Federal Award including Approved Cost** \$30,586,435

Sharing or Matching this Project Period

28. Authorized Treatment of Program Income

Additional Costs

29. Grants Management Officer - Signature

[REDACTED] ker

30. Remarks

Acceptance of this award, including the "Terms and Conditions," is acknowledged by the recipient when funds are drawn down or otherwise requested from the grant payment system.

Notice of Award



SABG
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

Issue Date: 05/17/2021

Center for Substance Abuse Treatment

Award Number: 1B08TI083977-01

FAIN: B08TI083977-01

Contact Person: [REDACTED]

Program: Substance Abuse Prevention & Treatment Block Grant

HEALTH CARE AUTHORITY
626 8TH AVENUE SE

OLYMPIA, WA 98501

Award Period: 09/01/2021 – 09/30/2025

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of \$30,586,435 (see “Award Calculation” in Section I) to HEALTH CARE AUTHORITY in support of the above referenced project. This award is pursuant to the authority of Subparts II&III,B, Title XIX, PHS Act/45 CFR Part96 and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Acceptance of this award including the “Terms and Conditions” is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

[REDACTED]

Grants Management Officer
Division of Grants Management

See additional information below

SECTION I – AWARD DATA – 1B08TI083977-01

FEDERAL FUNDS APPROVED: \$30,586,435

AMOUNT OF THIS ACTION (FEDERAL SHARE): \$30,586,435

CUMULATIVE AWARDS TO DATE: \$30,586,435

UNAWARDED BALANCE OF CURRENT YEAR'S FUNDS: \$0

Fiscal Information:

CFDA Number: 93.959

EIN: 1911412780A

Document 21B1WASAP

Number: TC6

Fiscal Year: 2021

IC	CAN	01
TI	C96D570	\$30,586,435

PCC: SAPT / OC: 4115

SECTION II – PAYMENT/HOTLINE INFORMATION – 1B08TI083977-01

Payments under this award will be made available through the HHS Payment Management System (PMS). PMS is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). Inquiries regarding payment should be directed to: The Division of Payment Management System, PO Box 6021, Rockville, MD 20852, Help Desk Support – Telephone Number: 1-877-614-5533.

The HHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. The telephone number is: 1-800-HHS-TIPS (1-800-447-8477). The mailing address is: Office of Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington, DC 20201.

SECTION III – TERMS AND CONDITIONS – 1B08TI083977-01

STANDARD TERMS AND CONDITIONS

SABG FY2021 ARPA funding

Remarks:

This Notice of Award (NoA) provides American Rescue Plan Act (ARPA) Supplemental Funding for the Substance Abuse Prevention and Treatment (SABG) Block Grant Program, in accordance with H.R. 1319 - American Rescue Plan Act of 2021. Consistent with HHS Disaster Relief Flexibilities, SAMHSA may waive requirements with respect to allowable activities, timelines, or reporting requirements for the SABG as deemed necessary to facilitate a grantee's response to coronavirus.

A proposal of the state's spending plan must be submitted by July 2, 2021 via the Web Block Grant Application System (WebBGAS). Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, grantees are required to upload the Plan document (Microsoft Word or pdf), using the associated tab in the State Information Section, Chief Executive Officer's Funding Agreement – Certifications and Assurances/Letter Designating Signatory Authority [SA]. Please title this document "ARPA Funding Plan 2021-SA" (States must upload separate proposals based on MHBG and SABG guidance into the WebBGAS system.

Further information on this is included in the letter from Acting Assistant Secretary for Mental Health and Substance Use, Tom Coderre.

Standard Terms of Award:

1) Acceptance of the Terms of an Award

By drawing or otherwise obtaining funds from the HHS Payment Management System, the recipient acknowledges acceptance of the terms and conditions of the award and is obligated to perform in accordance with the requirements of the award. Except for any waiver granted explicitly elsewhere in this section, this award does not constitute approval for waiver of any Federal statutory/regulatory requirements for a SABG. Once a recipient accepts an award, the contents of the Notice of Award (NoA) are binding on the recipient unless and until modified by a revised NoA signed by the GMO.

Certification Statement:

By drawing down funds, The recipient agrees to abide by the statutory requirements of all sections of the Substance Abuse Prevention and Treatment Block Grant (SABG) (Public Health Service Act, Sections 1921-1935 and sections 1941-1957) (42 U.S.C. 300x-21-300x-35 and 300x-51-300x-67, as amended), and other administrative and legal requirements as applicable for the duration of the award.

2) Availability of Funds

Funds provided under this grant must be obligated and expended by September 30, 2025.

3) Fiscal and administrative requirements

This NoA issued is subject to the administrative requirements for HHS block grants under 45 CFR Part 96, as applicable, and 45 CFR Part 75, as specified. Except for section 75.202 of Subpart C, and sections 75.351 through 75.353 of Subpart D, the requirements in Subpart C, Subpart D, and Subpart E do not apply to this program (reference 45 CFR Part 75 Subpart B, 75.101(d)).

Fiscal control and accounting procedures - Fiscal control and accounting procedures must be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant.

ARPA funding is being issued under a separate grant award number and has a unique subaccount in the Payment Management System. Accordingly, ARPA funds must be tracked and reported separately from other FY 2021 awarded funds, including COVID-19 Supplemental funding and the Annual Block Grant Allotment.

Audits - Grantees and subgrantees are responsible for obtaining audits in accordance with the Single Audit Act Amendments of 1996 (31 U.S.C. 7501-7507) and revised OMB Circular A-133, “Audits of State, Local Governments, and Non-Profit Organizations.” The audits shall be made by an independent auditor in accordance with generally accepted Government auditing standards covering financial audits.

Except for any waiver granted explicitly elsewhere in this section, this award does not constitute approval for waiver of any Federal statutory/regulatory requirements for a SABG.

4) Flow-down of requirements to sub-recipients

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients, in accordance with 45 CFR 75.351-75.353, Sub-recipient monitoring and management.

5) Executive Pay

The Consolidated Appropriations Act, 2021 (Public Law 116-260), signed into law on December 27, 2020 restricts the amount of direct salary to Executive Level II of the Federal Executive Pay scale. Effective January 3, 2021, the salary limitation for Executive Level II is \$199,300.

For awards issued prior to this change, if adequate funds are available in active awards, and if the salary cap increase is consistent with the institutional base salary, recipients may re-budget to accommodate the current Executive Level II salary level. However, no additional funds will be provided to these grant awards.

6) Marijuana Restriction:

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. 75.300(a) (requiring HHS to ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements.); 21 U.S.C. 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

7) SAM and DUNS Requirements

THIS AWARD IS SUBJECT TO REQUIREMENTS AS SET FORTH IN 2 CFR 25.110 CENTRAL CONTRACTOR REGISTRATION CCR) (NOW SAM) AND DATA UNIVERSAL NUMBER SYSTEM (DUNS) NUMBERS. 2 CFR Part 25 - Appendix A4

System of Award Management (SAM) and Universal Identifier Requirements

A. Requirement for System of Award Management:

Unless you are exempted from this requirement under 2 CFR 25.110, you, as the recipient, must maintain the currency of your information in the SAM, until you submit the final financial report required under this award or receive the final payment, whichever is later. This requires that you review and update the information at least annually after the initial registration, and more frequently if required by changes in your information or another award term.

B. Requirement for unique entity identifier If you are authorized (reference project description) to make subawards under this award, you:

1. Must notify potential subrecipients that no entity (see definition in paragraph C of this award term) may receive a subaward from you, unless the entity has provided its unique entity identifier to you.
2. May not make a subaward to an entity, unless the entity has provided its unique entity identifier to you.

C. Definitions. For purposes of this award term:

1. System of Award Management (SAM) means the federal repository into which an entity must provide information required for the conduct of business as a recipient. Additional information about registration procedures may be found at the SAM Internet site (currently at: <http://www.sam.gov>).
2. Unique entity identifier means the identifier required for SAM registration to uniquely identify business entities.
3. Entity, as it is used in this award term, means all of the following, as defined at 2 CFR Part 25, Subpart C:
 - a. A governmental organization, which is a state, local government, or Indian Tribe; b. A foreign public entity; c. A domestic or foreign nonprofit organization; d. A domestic or foreign for-profit organization; and e. A Federal agency, but only as a sub-recipient under an award or sub-award to a nonfederal entity.
4. Sub-award:
 - a. This term means a legal instrument to provide support for the performance of any portion of the substantive project or program for which you received this award and that you as the recipient award to an eligible sub-recipient. b. The term does not include your procurement of property and services needed to carry out the project or program (for further explanation, see 2 CFR 200.330). c. A sub-award may be provided through any legal agreement, including an agreement that you consider a contract.
5. Sub-recipient means an entity that: a. Receives a sub-award from you under this award; and b. Is accountable to you for the use of the federal funds provided by the sub-award.

8) Federal Financial Accountability and Transparency Act (FFATA)

Reporting Subawards and Executive Compensation, 2 CFR, Appendix A to Part 170

a. Reporting of first tier subawards.

1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates \$25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5) for a subaward to an entity (see definitions in paragraph e. of this award term).

2. Where and when to report.

i. You must report each obligating action described in paragraph a.1. of this award term to <http://www.fsrs.gov>.

ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)

3. What to report. You must report the information about each obligating action that the submission instructions posted at <http://www.fsrs.gov> specify.

b. Reporting Total Compensation of Recipient Executives.

1. Applicability and what to report. You must report total compensation for each of your five most highly compensated executives for the preceding completed fiscal year, if

i. the total Federal funding authorized to date under this award is \$25,000 or more;

ii. in the preceding fiscal year, you received (A) 80 percent or more of your annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and (B) \$25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and

iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at <http://www.sec.gov/answers/execomp.htm>.)

2. Where and when to report. You must report executive total compensation described in paragraph b. 1. of this award term:

i. As part of your registration profile at <https://www.sam.gov>.

ii. By the end of the month following the month in which this award is made, and annually thereafter.

c. Reporting of Total Compensation of Subrecipient Executives.

1. Applicability and what to report. Unless you are exempt as provided in paragraph d. of this award term, for each first tier subrecipient under this award, you shall report the names and total compensation of each of the subrecipient's five most highly

compensated executives for the subrecipient's preceding completed fiscal year, if

i. in the subrecipient's preceding fiscal year, the subrecipient received (A) 80 percent or more of its annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and (B) \$25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and subawards); and

ii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at <http://www.sec.gov/answers/execomp.htm>.)

2. Where and when to report. You must report subrecipient executive total compensation described in paragraph c. 1. of this award term:

i. To the recipient.

ii. By the end of the month following the month during which you make the subaward. For example, if a subaward is obligated on any date during the month of October of a given year (i.e., between October 1 and 31), you must report any required compensation information of the subrecipient by November 30 of that year.

d. Exemptions If, in the previous tax year, you had gross income, from all sources, under \$300,000, you are exempt from the requirements to report:

i. Subawards, and

ii. The total compensation of the five most highly compensated executives of any subrecipient.

e. Definitions. For purposes of this award term:

1. Entity means all of the following, as defined in 2 CFR part 25:

i. A Governmental organization, which is a State, local government, or Indian tribe;

ii. A foreign public entity;

iii. A domestic or foreign nonprofit organization;

iv. A domestic or foreign for-profit organization;

v. A Federal agency, but only as a subrecipient under an award or subaward to a non-Federal entity.

2. Executive means officers, managing partners, or any other employees in management positions.

3. Subaward:

i. This term means a legal instrument to provide support for the performance of any portion of the substantive project or program for which you received this award and that you as the recipient award to an eligible subrecipient.

ii. The term does not include your procurement of property and services needed to carry out the project or program (for further explanation, see Sec. __. 210 of the attachment to OMB Circular A-133, Audits of States, Local Governments, and Nonprofit Organizations).

iii. A subaward may be provided through any legal agreement, including an agreement that you or a subrecipient considers a contract.

4. Subrecipient means an entity that: i. Receives a subaward from you (the recipient) under this award; and ii. Is accountable to you for the use of the Federal funds provided by the subaward.

5. Total compensation means the cash and noncash dollar value earned by the executive during the recipient's or subrecipient's preceding fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)):

i. Salary and bonus.

ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.

iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives and are available generally to all salaried employees.

iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.

v. Above-market earnings on deferred compensation which is not tax-qualified. vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds \$10,000. [75 FR 55669, Sept. 14, 2010, as amended at 79 FR 75879, Dec. 19, 2014]

9) Mandatory Disclosures

Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the HHS Office of Inspector General (OIG), all information related to violations, or suspected violations, of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Subrecipients must disclose, in a timely manner, in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations, or suspected violations, of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Disclosures must be sent in writing to the awarding agency and to the HHS OIG at the following addresses:

U.S. Department of Health and Human Services Office of Inspector General

ATTN: Mandatory Grant Disclosures, Intake Coordinator 330 Independence Avenue, SW, Cohen Building Room 5527 Washington, DC 20201

Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or email:

MandatoryGranteeDisclosures@oig.hhs.gov

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371 remedies for noncompliance, including suspension or debarment (see 2 CFR parts 180 & 376 and 31 U.S.C. 3321).

10) The Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(G)), as amended, and 2 C.F.R. PART 175

The Trafficking Victims Protection Act of 2000 authorizes termination of financial assistance provided to a private entity, without penalty to the Federal government, if the recipient or subrecipient engages in certain activities related to trafficking in persons. SAMHSA may unilaterally terminate this award, without penalty, if a private entity recipient, or a private entity subrecipient, or their employees: a) Engage in severe forms of trafficking in persons during the period of time that the award is in effect; b) Procure a commercial sex act during the period of time that the award is in effect; or, c) Use forced labor in the performance of the award or subawards under the award. The text of the full award term is available at 2 C.F.R. 175.15(b). See <http://www.gpo.gov/fdsys/pkg/CFR-2012-title2-vol1/pdf/CFR-2012-title2-vol1-sec175-15.pdf>.

11) Drug-Free Workplace Requirements

The Drug-Free Workplace Act of 1988 (41 U.S.C. 701 et seq.) requires that all organizations receiving grants from any Federal agency agree to maintain a drug-free workplace. When the AR signed the application, the AR agreed that the recipient will provide a drug-free workplace and will comply with the requirement to notify SAMHSA if an employee is convicted of violating a criminal drug statute. Failure to comply with these requirements may be cause for debarment. Government wide requirements for Drug-Free Workplace for Financial Assistance are found in 2 CFR part 182; HHS implementing regulations are set forth in 2 CFR part 382.400. All recipients of SAMHSA grant funds must comply with the requirements in Subpart B (or Subpart C if the recipient is an individual) of Part 382.

12) Lobbying

No funds provided under the attached Notice of Award (NoA) may be used by you or any sub-recipient under the grant to support lobbying activities to influence proposed or pending federal or state legislation or appropriations. The prohibition relates to the use of federal grant funds and is not intended to affect your right or that of any other organization, to petition Congress or any other level of government, through the use of other nonfederal resources. Reference 45 CFR Part 93.

13) Accessibility Provisions

Grant recipients of Federal financial assistance (FFA) from HHS must administer their programs in compliance with Federal civil rights law. This means that recipients of HHS funds must ensure equal access to their programs without regard to a person's race, color, national origin, disability, age, and in some circumstances, sex and religion. This includes ensuring your programs are accessible to persons with limited English proficiency. The HHS Office for Civil Rights also provides guidance on complying with civil rights laws enforced by HHS. Please see

<http://www.hhs.gov/ocr/civilrights/understanding/section1557/index.html>. Recipients of FFA also have specific legal obligations for serving qualified individuals with disabilities. Please see <http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html>. Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under Federal civil rights laws at <https://www.hhs.gov/civil-rights/index.html> or call 1-800-368-1019 or TDD 1-800-537-7697. Also note that it is an HHS Departmental goal to ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations. For further guidance on providing culturally and linguistically appropriate services, recipients should review the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care at <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6>.

14) Audits

Non-Federal recipients that expend \$750,000 or more in federal awards during the recipient's fiscal year must obtain an audit conducted for that year in accordance with the provisions of 45 CFR 96.31.

Recipients are responsible for submitting their Single Audit Reports and the Data Collections Forms (SF-FAC) electronically to the to the Federal Audit Clearinghouse Visit disclaimer page (FAC) within the earlier of 30 days after receipt or nine months after the FY s end of the audit period. The FAC operates on behalf of the OMB.

For specific questions and information concerning the submission process: Visit the Federal Audit Clearinghouse at <https://harvester.census.gov/facweb> or Call FAC at the toll-free number: (800) 253-0696

Reporting Requirements:

Federal Financial Report (FFR)

The recipient is required to submit a Federal Financial Report (FFR) 90 days after the close of the performance period (project period). The SF-425 shall report total funds obligated and total funds expended by the grantee.

Effective January 1, 2021, award recipients are required to submit the SF-425 Federal Financial Report (FFR) via the Payment Management System (PMS). If the individual responsible for FFR submission does not already have an account with PMS, please [contact PMS](#) to obtain access.

Recipients must liquidate all obligations incurred under an award not later than ninety (90) days after the end of the award obligation and expenditure period (i.e., the project period) which also coincides with the due date for submission of the FINAL SF-425, *Federal Financial Report* (FFR). After ninety (90) days, letter of credit accounts are locked. SAMHSA does not approve extensions to the ninety (90) day post-award reconciliation/liquidation period. Therefore, recipients are expected to complete all work and reporting within the approved project period and the aforementioned 90-day post-award reconciliation/liquidation period. Recipients (late) withdrawal requests occurring after the aforementioned periods are denied. In rare instances, SAMHSA

may approve an extension to submit a FINAL SF-425 FFR report, but this is *not* an extension of the 90-day post award reconciliation/liquidation period, but rather only an extension to submit the Final SF-425 report (FFR).

Annual Report

Reporting on the ARPA funding is required. States must prepare and submit their respective reports utilizing WebBGAS. Failure to comply with these requirements may cause the initiation of enforcement actions that can culminate in discontinuation of SABG grants.

Your assigned SABG Program Official will provide further guidance and additional submission information.

In accordance with the regulatory requirements provided at 45 CFR 75.113 and Appendix XII to 45 CFR Part 75, recipients that have currently active Federal grants, cooperative agreements, and procurement contracts with cumulative total value greater than \$10,000,000 must report and maintain information in the System for Award Management (SAM) about civil, criminal, and administrative proceedings in connection with the award or performance of a Federal award that reached final disposition within the most recent five-year period. The recipient must also make semiannual disclosures regarding such proceedings. Proceedings information will be made publicly available in the designated integrity and performance system (currently the Federal Awardee Performance and Integrity Information System (FAPIIS)). Full reporting requirements and procedures are found in Appendix XII to 45 CFR Part 75.

Staff Contacts:

[REDACTED], Program Official

Phone: [REDACTED] Email: [REDACTED]

[REDACTED] Grants Specialist

Phone: [REDACTED] Email: [REDACTED] Fax: [REDACTED]

Exhibit B

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2020

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Substance Abuse Prevention and Treatment Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52

Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.);
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(g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and
(h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

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generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: [REDACTED] _____

Signature of CEO or Designee¹: _____

Title: Assistant Director, Division of Behavioral Health &
Recovery _____

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:



STATE OF WASHINGTON
HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

May 17, 2019

[REDACTED]
Senior Grants Policy Advisor
Division of Grants Management
SAMHSA
5600 Fishers Lane
Rockville, MD 20857

Dear [REDACTED]

I hereby delegate to the Assistant Director of the Division of Behavioral Health and Recovery (DBHR) of the Washington State Health Care Authority (HCA), the authority to act on my behalf in making application, reports (including Synar), and certifications related to the Unified Block Grant for the Substance Abuse Block Grant, the Mental Health Block Grant, the Projects for Assistance in Transition from Homelessness Grant, as well as any other discretionary grants administered by the HCA.

This delegation of signatory authority is for the person who holds the office of the Assistant Director of DBHR. The current Assistant Director of DBHR is [REDACTED]. This authority shall transfer to any and all individuals who are appointed Assistant Director of DBHR during my tenure as Director of HCA.

This delegation of authority is effective May 1, 2019. This delegation shall apply to any requirements for release of funds and other assistance necessary to implement or manage the grant process.

Your assistance with this matter is appreciated.

Sincerely,

[REDACTED]
Director

cc: [REDACTED] Chief Financial Officer, FS, HCA
[REDACTED] Assistant Director, DBHR, HCA
[REDACTED] Assistant Director, DLS, HCA
[REDACTED] Block Grant Administrator, DBHR, HCA
[REDACTED] PATH State Contact, DBHR, HCA

JAY INSLEE
Governor



STATE OF WASHINGTON
Office of the Governor

April 26, 2018

[REDACTED]
Grants Management Specialist
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear [REDACTED]

Washington State has a long history of implementing significant and innovative initiatives related to integration and care coordination. As of July 1, 2018, the Division of Behavioral Health and Recovery will transfer from the Department of Social and Health Services (DSHS) to the Health Care Authority (HCA) in order to fully integrate behavioral health and physical health care services.

This change requires the transition of the oversight, both financial and programmatic, of the Substance Abuse and Mental Health Services Administration grants from DSHS to HCA. Therefore, I am designating [REDACTED] Director of HCA, as the signature authority related to the Unified Block Grant for the Substance Abuse Block Grant and Mental Health Block Grant, the Projects for Assistance in Transition from Homelessness Grant as well as any other discretionary grants. This authority includes the signing of any standard federal forms such as Assurances, Certifications, and Disclosure of Lobbying Activities. In addition, I am designating HCA Director Susan E. Birch as the Single State Authority for Washington State.

The grants affected by this transition are listed in the enclosed document, which includes the Data Universal Numbering System (DUNS) number, Employer Identification Number and agency mailing address for each grant.

Thank you for your attention to this matter.

Very truly yours,

A handwritten signature in black ink, appearing to read "Jay Inslee".

Jay Inslee
Governor

Enclosure

cc: [REDACTED] DSHS Secretary
[REDACTED] MBA, BSN, RN, HCA Director



**Division of Behavioral Health and Recovery
Federal Grant Listing**

Grant Number	FAIN	CFDA #	Grant Name	DUNS	EIN	Agency Name	Agency Address
5U79SP020155	SP020155	93.243	Strategic Prevention Framework Partnerships for Success	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
5H79TI025995	TI025995	93.243	CSAT State Youth Treatment - Implementation	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
6H79SM061705	SM061705	93.243	Becoming Employed Start Today	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
5H79TI026138	TI026138	93.243	MAT-PDOA Project	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
1H79TI025570	TI025570	93.243	Access to Recovery	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
5H79SP022135	SP022135	93.243	Prevent Prescription Drug/Opioid Overdose-Related Deaths	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
1H79TI080249	TI080249	93.788	WA-STR addresses the Opiate Epidemic by increasing treatment & Prevention	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
2B09SM010056	SM010056	93.958	Mental Health Services Block Grant	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
2B08TI010056	TI010056	93.959	Substance Abuse Prevention and Treatment Block Grant	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
2X06SM016048	SM016048	93.150	Projects for Assistance in Transition from Homelessness	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2020

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Substance Abuse Prevention and Treatment Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32
Section 1935	Core Data Set	42 USC § 300x-35
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52

Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §5794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO)-11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: WASHINGTON

Name of Chief Executive Officer (CEO) or Designee: [REDACTED]

Signature of CEO or Designee [REDACTED]

Title: Assistant Director, Division of Behavioral Health & Recovery

Date Signed: 09/04/19

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:



STATE OF WASHINGTON
HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

May 17, 2019

██████████
Senior Grants Policy Advisor
Division of Grants Management
SAMHSA
5600 Fishers Lane
Rockville, MD 20857

Dear ██████████

I hereby delegate to the Assistant Director of the Division of Behavioral Health and Recovery (DBHR) of the Washington State Health Care Authority (HCA), the authority to act on my behalf in making application, reports (including Synar), and certifications related to the Unified Block Grant for the Substance Abuse Block Grant, the Mental Health Block Grant, the Projects for Assistance in Transition from Homelessness Grant, as well as any other discretionary grants administered by the HCA.

This delegation of signatory authority is for the person who holds the office of the Assistant Director of DBHR. The current Assistant Director of DBHR is ██████████. This authority shall transfer to any and all individuals who are appointed Assistant Director of DBHR during my tenure as Director of HCA.

This delegation of authority is effective May 1, 2019. This delegation shall apply to any requirements for release of funds and other assistance necessary to implement or manage the grant process.

Your assistance with this matter is appreciated.

Sincerely,

██████████
MBA, BSN, RN
Director

cc: ██████████ Chief Financial Officer, FS, HCA
██████████ Assistant Director, DBHR, HCA
██████████ Assistant Director, DLS, HCA
██████████ Block Grant Administrator, DBHR, HCA
██████████ PATH State Contact, DBHR, HCA

JAY INSLEE
Governor



STATE OF WASHINGTON
Office of the Governor

April 26, 2018

██████████
Grants Management Specialist
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1091
Rockville, MD 20857

Dear ██████████

Washington State has a long history of implementing significant and innovative initiatives related to integration and care coordination. As of July 1, 2018, the Division of Behavioral Health and Recovery will transfer from the Department of Social and Health Services (DSHS) to the Health Care Authority (HCA) in order to fully integrate behavioral health and physical health care services.

This change requires the transition of the oversight, both financial and programmatic, of the Substance Abuse and Mental Health Services Administration grants from DSHS to HCA. Therefore, I am designating ██████████ ██████████ Director of HCA, as the signature authority related to the Unified Block Grant for the Substance Abuse Block Grant and Mental Health Block Grant, the Projects for Assistance in Transition from Homelessness Grant as well as any other discretionary grants. This authority includes the signing of any standard federal forms such as Assurances, Certifications, and Disclosure of Lobbying Activities. In addition, I am designating HCA Director ██████████ as the Single State Authority for Washington State.

The grants affected by this transition are listed in the enclosed document, which includes the Data Universal Numbering System (DUNS) number, Employer Identification Number and agency mailing address for each grant.

Thank you for your attention to this matter.

Very truly yours,

Jay Inslee
Governor

Enclosure

cc: ██████████ DSHS Secretary
██████████ MBA, BSN, RN, HCA Director



**Division of Behavioral Health and Recovery
Federal Grant Listing**

Grant Number	FAIN	CFDA #	Grant Name	DUNS	EIN	Agency Name	Agency Address
5U79SP020155	SP020155	93.243	Strategic Prevention Framework Partnerships for Success	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
5H79TI025995	TI025995	93.243	CSAT State Youth Treatment - Implementation	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
6H79SM061705	SM061705	93.243	Becoming Employed Start Today	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
5H79TI026138	TI026138	93.243	MAT-PDOA Project	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
1H79TI025570	TI025570	93.243	Access to Recovery	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
5H79SP022135	SP022135	93.243	Prevent Prescription Drug/Opioid Overdose-Related Deaths	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
1H79TI080249	TI080249	93.788	WA-STR addresses the Opiate Epidemic by Increasing Treatment & Prevention	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
2B09SM010056	SM010056	93.958	Mental Health Services Block Grant	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
2B08TI010056	TI010056	93.959	Substance Abuse Prevention and Treatment Block Grant	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502
2X06SM016048	SM016048	93.150	Projects for Assistance in Transition from Homelessness	007207571	91-1412780	Health Care Authority	PO Box 45502 Olympia, WA 98504-5502

3101



STATE OF WASHINGTON
HEALTH CARE AUTHORITY

626 8th Avenue, SE • P.O. Box 42730 • Olympia, Washington 98504-2730

November 7, 2019

[REDACTED] State Project Officer
[REDACTED] State Project Officer
Substance Abuse and Mental Health Services Administration (SAMHSA)
5600 Fishers Lane, Suite 13N16-C
Rockville, MD 20857

Dear [REDACTED] and [REDACTED]

SUBJECT: ATTESTATION STATEMENT

As the Authorized Organization Representative and Assistant Director of the Division of Behavioral Health and Recovery (DBHR), please accept this attestation that I certify that the grantee organization/recipient, State and all sub-recipients will comply with the following NoA language:

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended...in full accordance with U.S. statutory...requirements."); 21 U.S.C. §§ 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under the FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned substance under federal law.

If you have any questions regarding the SAMHSA funded Block Grants, please contact [REDACTED] Federal Block Grant Manager at [REDACTED]

Sincerely,

[REDACTED]

[REDACTED] Deputy Division Director, DBHR

Cc: [REDACTED] Federal Block Grant Manager, DBHR

Exhibit C

From: [REDACTED]@samhsa.hhs.gov
To: [REDACTED]
Cc: [REDACTED]
Subject: B08T1083977: Termination Notice for COVID-19 Grant Funding
Date: Monday, March 24, 2025 2:38:47 PM

External Email

Dear Single State Authority Director and State Mental Health Commissioner,

During the COVID-19 pandemic, the Substance Abuse Mental Health Services Administration (SAMHSA) awarded several pandemic-related grants including the funded [Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 \(H.R.6074\) \(CRRSA\)](#) which provided funds to respond to the coronavirus outbreak and the [American Rescue Plan \(ARP\) Act of 2021\(H.R. 1319\)](#) which provided additional relief to address the continued impact of COVID-19 (i.e., coronavirus disease 2019) on the economy, public health, state and local governments, individuals, and businesses.

On April 10, 2023, President Biden signed [PL 188-3](#) terminating the national emergency concerning the COVID-19 pandemic. Consistent with the President's Executive Order 14222, Implementing the President's "Department of Government Efficiency" Cost Efficiency Initiative requiring a comprehensive review of SAMHSA grants, and where appropriate and consistent with applicable law, terminate such grants to reduce the overall Federal spending **this grant is being terminated effective March 24, 2025**. These grants were issued for a limited purpose: To ameliorate the effects of the pandemic. The end of the pandemic provides cause to terminate COVID-related grants. Now that the pandemic is over, the grants are no longer necessary.

In accordance with [45 CFR 96.30 \(4\)](#), block grant award recipients are required to provide a Financial Status Report (FFR) within 90 days of the close of the applicable statutory grant period. Recipients must liquidate all obligations incurred under an award after the end of the award obligation and expenditure period (i.e., the project period) which also coincides with the due date for submission of the FINAL SF-425, Federal Financial Report (FFR). Reimbursements after termination are allowable if it results from obligations which were properly incurred before the effective date of this termination.

Recipients are expected to complete all work immediately and the reconciliation/liquidation process no later than 90-days after the award period end date.

The related Payment Management System accounts will be restricted from drawdown going further. Additional information will be provided in the revised Notice of Award that will be issued to initiate the award period end date.

[[Correspondence Token: 4b824a81-4c89-48d9-96b4-3c0cc7bfcd4]] -- Do not delete or change this line. --

Please "Reply All" and do NOT delete eracorrespondence@nih.gov from the list of recipients or change the subject line.

Exhibit D

From: [REDACTED] ([SAMHSA/OFR](#))
To: [REDACTED]
Cc: [REDACTED]
Subject: B08T1083977: Block Grant Termination Notice for COVID-19 Awards (CRRSA and ARP)
Date: Friday, March 28, 2025 9:41:08 AM
Attachments: [95-8648 BG hearing procedure.pdf](#)

External Email

Dear Single State Authority Director and State Mental Health Commissioner,
You received notification on March 24, 2025, that your award was being terminated. This notice replaces and supersedes the previous notice.

During the COVID-19 pandemic, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded several pandemic-related grants funded by the [Coronavirus Response and Relief Supplemental Appropriations Act](#) (CRRSA) which provided funds to respond to the coronavirus outbreak and the [American Rescue Plan](#) (ARP) Act which provided additional relief to address the continued impact of COVID-19.

The termination of this award is for cause. The block grant provisions at [42 U.S.C. §300x-55](#) permit termination if the state “has materially failed to comply with the agreements or other conditions required for the receipt of a grant under the program involved.” The end of the pandemic provides cause to terminate COVID-related grants and cooperative agreements. These grants and cooperative agreements were issued for a limited purpose: to ameliorate the effects of the pandemic. Now that the pandemic is over, the grants and cooperative agreements are no longer necessary as their limited purpose has run out. Termination of this award is effective as of 11:59PM EDT, March 24, 2025.

In accordance with [45 CFR 96.30 \(4\)](#), block grant award recipients are required to provide a Financial Status Report (FFR) no later than 90 calendar days after March 24, 2025. Recipients must liquidate all obligations incurred under an award no later than 90 calendar days after March 24, 2025, which also coincides with the due date for submission of the FINAL SF-425, Federal Financial Report (FFR). Reimbursements after termination are allowable if the reimbursements result from obligations which were properly incurred on or before March 24, 2025.

Recipients are expected to cease all activities immediately and complete the reconciliation/liquidation process no later than 90 calendar days after the termination effective date.

Opportunity for Hearing:

Per the enclosed hearing procedures, block grant recipients may request a hearing to dispute this decision by submitting a written notice to the Substance Abuse and Mental Health Services Administration (SAMHSA) requesting a hearing within 15 calendar days of the date of this notice to: SAMHSAgrants@samhsa.hhs.gov. The request for a hearing must include a copy of this termination notice and a brief statement of why this decision should not be upheld.

Enclosure

[[Correspondence Token: 593f7461-2116-43c1-be2b-a1ba5068bbb4]] -- Do not delete or change this line. --

Please 'Reply All' and do NOT delete eracorrespondence@nih.gov from the list of recipients or change the subject line.

Exhibit E

**Recipient Information****1. Recipient Name**HEALTH CARE AUTHORITY
626 8TH AVENUE SE

OLYMPIA, WA 98501

2. Congressional District of Recipient

10

3. Payment System Identifier (ID)

1911412780A1

4. Employer Identification Number (EIN)

911412780

5. Data Universal Numbering System (DUNS)

007207571

6. Recipient's Unique Entity Identifier**7. Project Director or Principal Investigator**

[REDACTED]

8. Authorized Official**Federal Agency Information****9. Awarding Agency Contact Information**[REDACTED]
Grants Management Specialist
Center for Mental Health Services
[REDACTED]
[REDACTED]**10. Program Official Contact Information**[REDACTED]
Center for Mental Health Services
[REDACTED]
[REDACTED]**Federal Award Information****11. Award Number**

1B09SM085384-01

12. Unique Federal Award Identification Number (FAIN)

B09SM085384

13. Statutory Authority

Subparts I&III,B,Title XIX,PHS Act/45 CFR Part96

14. Federal Award Project Title

Block Grants for Community Mental Health Services

15. Assistance Listing Number

93.958

16. Assistance Listing Program Title

Block Grants for Community Mental Health Services

17. Award Action Type

New Competing

18. Is the Award R&D?

No

Summary Federal Award Financial Information**19. Budget Period Start Date 09/01/2021 – End Date 09/30/2025****20. Total Amount of Federal Funds Obligated by this Action** \$33,202,279

20 a. Direct Cost Amount \$33,202,279

20 b. Indirect Cost Amount \$0

21. Authorized Carryover**22. Offset****23. Total Amount of Federal Funds Obligated this budget period** \$33,202,279**24. Total Approved Cost Sharing or Matching, where applicable** \$0**25. Total Federal and Non-Federal Approved this Budget Period** \$33,202,279**26. Project Period Start Date 09/01/2021 – End Date 09/30/2025****27. Total Amount of the Federal Award including Approved Cost** \$33,202,279

Sharing or Matching this Project Period

28. Authorized Treatment of Program Income

Additional Costs

29. Grants Management Officer - Signature

[REDACTED]

30. Remarks

Acceptance of this award, including the "Terms and Conditions," is acknowledged by the recipient when funds are drawn down or otherwise requested from the grant payment system.

Notice of Award



MHBG
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

Issue Date: 05/17/2021

Center for Mental Health Services

Award Number: 1B09SM085384-01

FAIN: B09SM085384-01

Contact Person: [REDACTED]

Program: Block Grants for Community Mental Health Services

HEALTH CARE AUTHORITY
626 8TH AVENUE SE

OLYMPIA, WA 98501

Award Period: 09/01/2021 – 09/30/2025

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of \$33,202,279 (see “Award Calculation” in Section I) to HEALTH CARE AUTHORITY in support of the above referenced project. This award is pursuant to the authority of Subparts I&III,B, Title XIX, PHS Act/45 CFR Part96 and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Acceptance of this award including the “Terms and Conditions” is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

[REDACTED]

Grants Management Officer
Division of Grants Management

See additional information below

SECTION I – AWARD DATA – 1B08S3 097-9M01

FEDERAL FUNDS APPROVED: \$33,202,279

A3 OHNT OF T(IS ACTION IFEDERA) S(AREI: \$33,202,279

CUMULATIVE AWARDS TO DATE: \$33,202,279

UNAWARDED BALANCE OF CURRENT YEAR’S FUNDS: \$0

Fiscal Information:

CFDA Number: 93.958

EIN: 1911412780A

Document 21B1WACM

Number: HSC6

Fiscal Year: 2021

IC	CAN	01
SM	C96D540	\$33,202,279

PCC: CMHS COC: 4115

SECTION II – PA/ 3 ENTG OT) INE INFOR3 ATION – 1B08S3 097-9M01

Payments under this award will be made available through the HHS Payment Management System (PMS). PMS is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). Inquiries regarding payment should be directed to: The Division of Payment Management System, PO Box 6021, Rockville, MD 20852, Help Desk Support – Telephone Number: 1-877-614-5533.

The HHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. The telephone number is: 1-800-HHS-TIPS (1-800-447-8477). The mailing address is: Office of Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington, DC 20201.

SECTION III – TER3 S AND CONDITIONS – 1B08S3 097-9M01

STANDARD TER3 S AND CONDITIONS

3 (B2 F/ k0k1 ARPA Yinding

Remarks:

This Notice of Award (NoA) provides American Rescue Plan Act of 2021 (ARPA) funding for the Community Mental Health Services (MHBG) Block Grant Program, in accordance with H.R. 1319 – American Rescue Plan Act of 2021 the ARPA Act, 2021 [P.L. 117-2]. Consistent with HHS Disaster Relief Flexibilities, SAMHSA may waive requirements with respect to allowable activities, timelines, or reporting requirements for the MHBG, as deemed necessary to facilitate a grantee's response to coronavirus.

A proposal of the state's spending plan must be submitted by July 2, 2021 via the Web Block Grant Application System (WebBGAS).

Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, grantees are required to upload the Plan document (Microsoft Word or pdf), using the associated tab in the State Information Section, Chief Executive Officer's Funding Agreement – Certifications and Assurances/Letter Designating Signatory Authority [MH]. Please title this document "ARPA Funding Plan 2021-MH". States must upload separate proposals based on MHBG and SABG guidance into the WebBGAS system.

Further information on this is included in the letter from Acting Assistant Secretary for Mental Health and Substance Use, Tom Coderre

Standard Terms of Award:

11 Acceptance of Terms of Award

By drawing or otherwise obtaining funds from the HHS Payment Management System, the recipient acknowledges acceptance of the terms and conditions of the award and is obligated to perform in accordance with the requirements of the award. Except for any waiver granted explicitly elsewhere in this section, this award does not constitute approval for waiver of any Federal statutory/regulatory requirements for a MHBG. Once an award is accepted by a recipient, the contents of the Notice of Award (NoA) are binding on the recipient unless and until modified by a revised NoA signed by the GMO.

Certification Statement: By drawing down funds, The recipient agrees to abide by the statutory requirements of all sections of the Mental Health Block Grant (MHBG) (Public Health Service Act, Sections 1911-1920 and sections 1941-1957) (42 U.S.C. 300x-1-300x-9 and 300x-51-300x-67, as amended), and other administrative and legal requirements as applicable for the duration of the award.

12 Official Form Designee

The States Chief Executive Officer, or authorized designee is considered the official form designee for this grant. The SAMHSA GMS and the MHBG Program Officer must be notified immediately before any changes in this key position are made. Please note that individuals that are suspended or debarred are prohibited from serving on Federal grant awards.

13 Availability of Funds

Funds provided under this grant must be obligated and expended by September 30, 2025.

14 Fiscal and administrative requirements

This award is subject to the administrative requirements for HHS block grants under 45 CFR Part 96, Subpart C, and 45 CFR Part 75, as specified. Except for section 75.202 of Subpart C, and sections 75.351 through 75.353 of Subpart D, the requirements in Subpart C, Subpart D, and Subpart E do not apply to this program (reference 45 CFR Part 75 Subpart B, 75.101(d)).

Fiscal control and accounting procedures - Fiscal control and accounting procedures must be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant.

ARPA funding is being issued under a separate grant award number and has a unique subaccount in the Payment Management System. Accordingly, ARPA funds must be tracked and reported separately from other FY 2021 awarded funds, including COVID-19 Supplemental funding and the Annual Block Grant Allotment.

Audits - Grantees and subgrantees are responsible for obtaining audits in accordance with the Single Audit Act Amendments of 1996 (31 U.S.C. 7501-7507) and revised OMB Circular A-133, "Audits of State, Local Governments, and Non-Profit Organizations." The audits shall be made by an independent auditor in accordance with generally accepted Government auditing standards covering financial audits.

71 Ffowldown oYre4uirements to subUrecihients

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients, in accordance with 45 CFR 75.351-75.353, Sub-recipient monitoring and management.

5l Earfq Serious 3 entaf Ifiness SetUAside

The 21st Century Cures Act, P.L. 114-255 amended Section 1920(c) of the Public Health Service Act (42 U.S.C. 300x 9(c)). States must set-aside not less than 10 percent of their total MHBG allocation amount for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount, the State receives for a fiscal year, states have the flexibility to expend not less than 20 percent of such amount by the end of the succeeding fiscal year.

xl E6ecutiye Paq

The Consolidated Appropriations Act, 2021 (Public Law 116-260), signed into law on December 27, 2020 restricts the amount of direct salary to Executive Level II of the Federal Executive Pay scale. Effective January 3, 2021, the salary limitation for Executive Level II is \$199,300.

For awards issued prior to this change, if adequate funds are available in active awards, and if the salary cap increase is consistent with the institutional base salary, recipients may re-budget to accommodate the current Executive Level II salary level. However, no additional funds will be provided to these grant awards.

9l 3 arijuana Restriction:

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 C.F.R. 75.300(a) (requiring HHS to ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements.); 21 U.S.C. 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

81 SA3 and DHNS Re4uirements

THIS AWARD IS SUBJECT TO REQUIREMENTS AS SET FORTH IN 2 CFR 25.110 CENTRAL CONTRACTOR REGISTRATION CCR) (NOW SAM) AND DATA UNIVERSAL NUMBER SYSTEM (DUNS) NUMBERS. 2 CFR Part 25 - Appendix A4

System of Award Management (SAM) and Universal Identifier Requirements

A. Requirement for System of Award Management:

Unless you are exempted from this requirement under 2 CFR 25.110, you, as the recipient, must maintain the currency of your information in the SAM, until you submit the final financial report required under this award or receive the final payment, whichever is later. This requires that you review and update the information at least annually after the initial registration, and more frequently if required by changes in your information or another award term.

B. Requirement for unique entity identifier If you are authorized (reference project description) to make subawards under this award, you:

1. Must notify potential subrecipients that no entity (see definition in paragraph C of this award term) may receive a subaward from you, unless the entity has provided its unique entity identifier to you.
2. May not make a subaward to an entity, unless the entity has provided its unique entity identifier to you.

C. Definitions. For purposes of this award term:

1. System of Award Management (SAM) means the federal repository into which an entity must provide information required for the conduct of business as a recipient. Additional information about registration procedures may be found at the SAM Internet site (currently at: <http://www.sam.gov>).
2. Unique entity identifier means the identifier required for SAM registration to uniquely identify business entities.
3. Entity, as it is used in this award term, means all of the following, as defined at 2 CFR Part 25, Subpart C:
 - a. A governmental organization, which is a state, local government, or Indian Tribe; b. A foreign public entity; c. A domestic or foreign nonprofit organization; d. A domestic or foreign for-profit organization; and e. A Federal agency, but only as a sub-recipient under an award or sub-award to a nonfederal entity.
4. Sub-award:

a. This term means a legal instrument to provide support for the performance of any portion of the substantive project or program for which you received this award and that you as the recipient award to an eligible sub-recipient. b. The term does not include your procurement of property and services needed to carry out the project or program (for further explanation, see 2 CFR 200.330). c. A sub-award may be provided through any legal agreement, including an agreement that you consider a contract.

5. Sub-recipient means an entity that: a. Receives a sub-award from you under this award; and b. Is accountable to you for the use of the federal funds provided by the sub-award.

101 Federal Financial Accountability and Transparency Act (FFATA)

Reporting Subawards and Executive Compensation, 2 CFR, Appendix A to Part 170

a. Reporting of first tier subawards.

1. Applicability. Unless you are exempt as provided in paragraph d. of this award term, you must report each action that obligates \$25,000 or more in Federal funds that does not include Recovery funds (as defined in section 1512(a)(2) of the American Recovery and Reinvestment Act of 2009, Pub. L. 111-5) for a subaward to an entity (see definitions in paragraph e. of this award term).

2. Where and when to report.

i. You must report each obligating action described in paragraph a.1. of this award term to <http://www.fsrs.gov>.

ii. For subaward information, report no later than the end of the month following the month in which the obligation was made. (For example, if the obligation was made on November 7, 2010, the obligation must be reported by no later than December 31, 2010.)

3. What to report. You must report the information about each obligating action that the submission instructions posted at <http://www.fsrs.gov> specify.

b. Reporting Total Compensation of Recipient Executives.

1. Applicability and what to report. You must report total compensation for each of your five most highly compensated executives for the preceding completed fiscal year, if

i. the total Federal funding authorized to date under this award is \$25,000 or more;

ii. in the preceding fiscal year, you received (A) 80 percent or more of your annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and (B) \$25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and

iii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation

information, see the U.S. Security and Exchange Commission total compensation filings at <http://www.sec.gov/answers/execomp.htm>.)

2. Where and when to report. You must report executive total compensation described in paragraph b. 1. of this award term:

i. As part of your registration profile at <https://www.sam.gov>.

ii. By the end of the month following the month in which this award is made, and annually thereafter.

c. Reporting of Total Compensation of Subrecipient Executives.

1. Applicability and what to report. Unless you are exempt as provided in paragraph d. of this award term, for each first tier subrecipient under this award, you shall report the names and total compensation of each of the subrecipient's five most highly compensated executives for the subrecipient's preceding completed fiscal year, if

i. in the subrecipient's preceding fiscal year, the subrecipient received (A) 80 percent or more of its annual gross revenues from Federal procurement contracts (and subcontracts) and Federal financial assistance subject to the Transparency Act, as defined at 2 CFR 170.320 (and subawards); and (B) \$25,000,000 or more in annual gross revenues from Federal procurement contracts (and subcontracts), and Federal financial assistance subject to the Transparency Act (and subawards); and

ii. The public does not have access to information about the compensation of the executives through periodic reports filed under section 13(a) or 15(d) of the Securities Exchange Act of 1934 (15 U.S.C. 78m(a), 78o(d)) or section 6104 of the Internal Revenue Code of 1986. (To determine if the public has access to the compensation information, see the U.S. Security and Exchange Commission total compensation filings at <http://www.sec.gov/answers/execomp.htm>.)

2. Where and when to report. You must report subrecipient executive total compensation described in paragraph c. 1. of this award term:

i. To the recipient.

ii. By the end of the month following the month during which you make the subaward. For example, if a subaward is obligated on any date during the month of October of a given year (i.e., between October 1 and 31), you must report any required compensation information of the subrecipient by November 30 of that year.

d. Exemptions If, in the previous tax year, you had gross income, from all sources, under \$300,000, you are exempt from the requirements to report:

i. Subawards, and

ii. The total compensation of the five most highly compensated executives of any subrecipient.

e. Definitions. For purposes of this award term:

1. Entity means all of the following, as defined in 2 CFR part 25:

i. A Governmental organization, which is a State, local government, or Indian tribe;

ii. A foreign public entity;

- iii. A domestic or foreign nonprofit organization;
 - iv. A domestic or foreign for-profit organization;
 - v. A Federal agency, but only as a subrecipient under an award or subaward to a non-Federal entity.
2. Executive means officers, managing partners, or any other employees in management positions.
3. Subaward:
- i. This term means a legal instrument to provide support for the performance of any portion of the substantive project or program for which you received this award and that you as the recipient award to an eligible subrecipient.
 - ii. The term does not include your procurement of property and services needed to carry out the project or program (for further explanation, see Sec. __. 210 of the attachment to OMB Circular A-133, Audits of States, Local Governments, and Nonprofit Organizations).
 - iii. A subaward may be provided through any legal agreement, including an agreement that you or a subrecipient considers a contract.
4. Subrecipient means an entity that: i. Receives a subaward from you (the recipient) under this award; and ii. Is accountable to you for the use of the Federal funds provided by the subaward.
5. Total compensation means the cash and noncash dollar value earned by the executive during the recipient's or subrecipient's preceding fiscal year and includes the following (for more information see 17 CFR 229.402(c)(2)):
- i. Salary and bonus.
 - ii. Awards of stock, stock options, and stock appreciation rights. Use the dollar amount recognized for financial statement reporting purposes with respect to the fiscal year in accordance with the Statement of Financial Accounting Standards No. 123 (Revised 2004) (FAS 123R), Shared Based Payments.
 - iii. Earnings for services under non-equity incentive plans. This does not include group life, health, hospitalization or medical reimbursement plans that do not discriminate in favor of executives and are available generally to all salaried employees.
 - iv. Change in pension value. This is the change in present value of defined benefit and actuarial pension plans.
 - v. Above-market earnings on deferred compensation which is not tax-qualified.
 - vi. Other compensation, if the aggregate value of all such other compensation (e.g. severance, termination payments, value of life insurance paid on behalf of the employee, perquisites or property) for the executive exceeds \$10,000. [75 FR 55669, Sept. 14, 2010, as amended at 79 FR 75879, Dec. 19, 2014]

111.3 andatorq Disclosures

Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the HHS Office of Inspector General (OIG), all information

related to violations, or suspected violations, of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Subrecipients must disclose, in a timely manner, in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations, or suspected violations, of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Disclosures must be sent in writing to the awarding agency and to the HHS OIG at the following addresses:

U.S. Department of Health and Human Services Office of Inspector General

ATTN: Mandatory Grant Disclosures, Intake Coordinator 330 Independence Avenue, SW, Cohen Building Room 5527 Washington, DC 20201

Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or email: MandatoryGranteeDisclosures@oig.hhs.gov

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371 remedies for noncompliance, including suspension or debarment (see 2 CFR parts 180 & 376 and 31 U.S.C. 3321).

1kl Tve Trafficking Victims Protection Act of 2000 1kk H.S.C. x10M2 II, as amended, and k C.F.R. PART 1x7

The Trafficking Victims Protection Act of 2000 authorizes termination of financial assistance provided to a private entity, without penalty to the Federal government, if the recipient or subrecipient engages in certain activities related to trafficking in persons. SAMHSA may unilaterally terminate this award, without penalty, if a private entity recipient, or a private entity subrecipient, or their employees: a) Engage in severe forms of trafficking in persons during the period of time that the award is in effect; b) Procure a commercial sex act during the period of time that the award is in effect; or, c) Use forced labor in the performance of the award or subawards under the award. The text of the full award term is available at 2 C.F.R. 175.15(b). See <http://www.gpo.gov/fdsys/pkg/CFR-2012-title2-vol1/pdf/CFR-2012-title2-vol1-sec175-15.pdf>.

1-1 Drug-Free Workplace Requirements

The Drug-Free Workplace Act of 1988 (41 U.S.C. 701 et seq.) requires that all organizations receiving grants from any Federal agency agree to maintain a drug-free workplace. When the AR signed the application, the AR agreed that the recipient will provide a drug-free workplace and will comply with the requirement to notify SAMHSA if an employee is convicted of violating a criminal drug statute. Failure to comply with these requirements may be cause for debarment. Government wide requirements for Drug-Free Workplace for Financial Assistance are found in 2 CFR part 182; HHS implementing regulations are set forth in 2 CFR part 382.400. All recipients of SAMHSA grant funds must comply with the requirements in Subpart B (or Subpart C if the recipient is an individual) of Part 382.

1M) Lobbying

No funds provided under the attached Notice of Award (NoA) may be used by you or any sub-recipient under the grant to support lobbying activities to influence proposed or pending federal or state legislation or appropriations. The prohibition relates to the

use of federal grant funds and is not intended to affect your right or that of any other organization, to petition Congress or any other level of government, through the use of other nonfederal resources. Reference 45 CFR Part 93.

171 Accessibility Provisions

Grant recipients of Federal financial assistance (FFA) from HHS must administer their programs in compliance with Federal civil rights law. This means that recipients of HHS funds must ensure equal access to their programs without regard to a person's race, color, national origin, disability, age, and in some circumstances, sex and religion. This includes ensuring your programs are accessible to persons with limited English proficiency. The HHS Office for Civil Rights also provides guidance on complying with civil rights laws enforced by HHS. Please see <http://www.hhs.gov/ocr/civilrights/understanding/section1557/index.html>. Recipients of FFA also have specific legal obligations for serving qualified individuals with disabilities. Please see <http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html>. Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under Federal civil rights laws at <https://www.hhs.gov/civil-rights/index.html> or call 1-800-368-1019 or TDD 1-800-537-7697. Also note that it is an HHS Departmental goal to ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations. For further guidance on providing culturally and linguistically appropriate services, recipients should review the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care at <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6>.

151 Audits

Non-Federal recipients that expend \$750,000 or more in federal awards during the recipient's fiscal year must obtain an audit conducted for that year in accordance with the provisions of 45 CFR 96.31.

Recipients are responsible for submitting their Single Audit Reports and the Data Collections Forms (SF-FAC) electronically to the Federal Audit Clearinghouse Visit disclaimer page (FAC) within the earlier of 30 days after receipt or nine months after the FY's end of the audit period. The FAC operates on behalf of the OMB.

For specific questions and information concerning the submission process: Visit the Federal Audit Clearinghouse at <https://harvester.census.gov/facweb> or Call FAC at the toll-free number: (800) 253-0696

Reporting Requirements:

Federal Financial Report (FFR)

The recipient is required to submit a Federal Financial Report (FFR) 90 days after the close of the performance period (project period). The SF-425 shall report total funds obligated and total funds expended by the grantee.

Effective January 1, 2021, award recipients are required to submit the SF-425 Federal Financial Report (FFR) via the Payment Management System (PMS). If the individual

responsible for FFR submission does not already have an account with PMS, please [contact PMS](#) to obtain access.

Recipients must liquidate all obligations incurred under an award not later than ninety (90) days after the end of the award obligation and expenditure period (i.e., the project period) which also coincides with the due date for submission of the FINAL SF-425, *Federal Financial Report* (FFR). After ninety (90) days, letter of credit accounts are locked. SAMHSA does not approve extensions to the ninety (90) day post-award reconciliation/liquidation period. Therefore, recipients are expected to complete all work and reporting within the approved project period and the aforementioned 90-day post-award reconciliation/liquidation period. Recipients (late) withdrawal requests occurring after the aforementioned periods are denied. In rare instances, SAMHSA may approve an extension to submit a FINAL SF-425 FFR report, but this is *not* an extension of the 90-day post award reconciliation/liquidation period, but rather only an extension to submit the Final SF-425 report (FFR).

Annual Report

Reporting on the ARPA funding is required. States must prepare and submit their respective reports utilizing WebBGAS. Failure to comply with these requirements may cause the initiation of enforcement actions that can culminate in discontinuation of MHBG grants.

Your assigned MHBG Program Official will provide further guidance and additional submission information.

In accordance with the regulatory requirements provided at 45 CFR 75.113 and Appendix XII to 45 CFR Part 75, recipients that have currently active Federal grants, cooperative agreements, and procurement contracts with cumulative total value greater than \$10,000,000 must report and maintain information in the System for Award Management (SAM) about civil, criminal, and administrative proceedings in connection with the award or performance of a Federal award that reached final disposition within the most recent five-year period. The recipient must also make semiannual disclosures regarding such proceedings. Proceedings information will be made publicly available in the designated integrity and performance system (currently the Federal Awardee Performance and Integrity Information System (FAPIIS)). Full reporting requirements and procedures are found in Appendix XII to 45 CFR Part 75.

Staff Contacts:

[REDACTED], Program Official

Phone: [REDACTED] Email: [REDACTED]

[REDACTED], Grants Specialist

Phone: ([REDACTED])

Email: [REDACTED]

Fax: [REDACTED]

Exhibit F

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2021

U.S. Department of Health and Human Services
 Substance Abuse and Mental Health Services Administrations
 Funding Agreements
 as required by
 Community Mental Health Services Block Grant Program
 as authorized by
 Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
 and
 Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee¹: _____

Title: _____

Date Signed: _____

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2021

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Section 1917	Application for Grant	42 USC § 300x-6
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53
Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

- a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds \$25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
 - a. Checking the Exclusion Extract located on the System for Award Management (SAM) at <http://sam.gov>
 - b. Collecting a certification statement similar to paragraph (a)
 - c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

- a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
- b. Establishing an ongoing drug-free awareness program to inform employees about--
 1. The dangers of drug abuse in the workplace;
 2. The grantee's policy of maintaining a drug-free workplace;
 3. Any available drug counseling, rehabilitation, and employee assistance programs; and
 4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
 1. Abide by the terms of the statement; and
 2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
- f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
 1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
 2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs.

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart I and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee¹: _____

Title: Director, Division of Behavioral Health & Recovery

Date Signed: 8/18/2020

mm/dd/yyyy

¹If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Washington

COVID-19 Supplemental Funding Plan for FY21

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

Center for Mental Health Services
Division of State and Community Systems Development

Mental Health Block Grant COVID Supplemental Funding Plan

WA State Summary

The COVID-19 pandemic has had a significant impact on people with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) in Washington State. During the first half of 2019, 8.2% of adults over 18 years of age had symptoms of anxiety disorder and 6.6% had symptoms of depressive disorder. By comparison, in the most recent Household Pulse Survey from the Centers for Disease Control examining trends from February 17, 2021 to March 1, 2021, this prevalence quadrupled to 33.4% for anxiety and 27.7% for depression (in Washington state, rates were slightly higher with 34.2% for anxiety, 14th highest of the 50 states, and 27.8% for depression, 23rd highest of the 50 states). The age group with the highest prevalence rates nationally is 18–29-year-olds (47.2% reporting anxiety, and 42.2% reporting depression). The devastating impacts of the COVID-19 pandemic have clearly impacted young adults' mental health and substance use (a population already at high risk).

As the state and nation emerge from early Phases of the pandemic, the resulting impacts of the last year are a salient concern. People face potentially new obstacles such as continued mental health issues, overcoming the potential disruptions in school, work, and finances, and re-engaging in social life with continued recommendations from the CDC and local health departments (e.g., mask mandates). This is a critical time to address potential harms and to encourage engagement in both adaptive coping behaviors and unique strategies of social engagement within current public health guidelines to reduce high-risk substance use and worsening mental health symptoms, in both adults and youth.

HCA's Division of Behavioral Health and Recovery has reviewed the *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* and allocated a percentage of the total potential COVID-19 relief supplemental funding to address principles focused on recovery needs, support for the behavioral health workforce, particularly of Peers and Recovery Support Peers, and trauma-informed treatment services. The budget summary, on the following pages, provides the detailed amounts allocated across the continuum of behavioral health services through a wide variety of projects, treatment funds provided through our Behavioral Health Administrative Service Organizations (BH-ASO's) and Tribes. WA Health Care Authority, with input from partners, including the Behavioral Health Advisory Council, respectfully submits the proposals you will find in the pages to follow.

As part of our effort to seek stakeholder input, the Behavioral Health Advisory Council co-hosted a meeting with the Health Care Authority to invite input from various partners and representatives from across the state's behavioral health system (from Peers to school districts, as well as counties, managed care organizations and others). Input on the proposals was received at the end of the event, which helped to inform the direction, as well as solidify the allocations to each section and confirm what flexibilities to seek within the application for these COVID-19 relief supplemental funds. In addition to waiver flexibilities, the Health Care Authority may also require some flexibility to move allocations from one proposal, to another, within those in this application, in the event a particular proposal is particularly successful and requires funding allocation from another proposal which may not require the entire allocation presented in this application.

Within the budget summary below, you will find the proposed project titles, a brief description and number for each project under the sections of First Episode Psychosis, Treatment, Recovery Support Services and Crisis Services. In the pages that follow, a longer project narrative will include the project title, budgeted amount, a description, or scope of work summary, as well as a narrative of how the project addresses state needs and gaps, especially gaps in equity.

WA is grateful to SAMHSA for the opportunity to apply for the COVID-19 relief supplemental funds, as this has been an unprecedented year of extreme stressors to the most vulnerable among us, and the funding will undoubtedly support those persons at greatest risk, as well as those who seek support in treatment and ongoing recovery.

Project List and Budget Table

FEP Set-Aside			
Project #	Project Title	Project Description	Proposed Budget
Project #: BGCE-CYF4	Early Identification and Intervention for Psychosis	New Journeys treatment team to travel to the home, school or elsewhere in the community to provide assessment, screening and behavioral health services for individuals and families affected by First Episode Psychosis (FEP).	\$ 2,306,685
Total FEP Set-Aside			\$ 2,306,685
Treatment			
Children, Youth and Family Treatment Funding			
Project #	Project Title	Project Description	Proposed Budget
Project #: BGCE-CYF2	Developing Wraparound and Intensive Services (WiSe) Workforce Support	Developing Wraparound and Intensive Service (WiSe) workforce to support youth with Intellectual Disabilities/Developmental Disabilities (including Autism Spectrum Disorder (ASD)).	\$ 200,000
Project #: BGCE-CYF5	Trauma Focused Cognitive Behavioral Therapy Training	Trauma Focused Cognitive Behavioral Therapy (CBT) Training for clinicians serving children and youth returning to school as part of the triage process post screening.	\$ 376,671
Adult Treatment Funding			

Project #: BGCE- MHA1	Cognitive Behavioral Therapy for Psychosis	Expansion of current contract to deliver Cognitive Behavioral Therapy for Psychosis to a cohort of clinicians who are serving people on 90/180 involuntary civil commitment orders.	\$ 130,000
Project #: BGCE- MHA2	Trauma Informed Care for Designated Crisis Responders	Modify curriculum of Trauma Informed Care training specifically for Designated Crisis Responders to incorporate the skills into their practice.	\$ 50,000
Project #: BGCE- MHA3	Mental Health Specialist Training	Develop a curriculum for a 100-hour course for Mental Health (MH) professionals to secure credentials to become an Older Adult Mental Health Specialist, Intellectual Disabilities /Developmental Disabilities (ID/DD) Mental Health Specialist, and Ethnic Minority Mental Health Specialist.	\$ 396,671
BH-ASO Treatment Funding			
Project #: BGCE- ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding	The community mental health services provided include but are not limited to outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, residents of the service areas who have been discharged from inpatient treatment at a mental health facility, day treatment or other partial hospitalization services, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, or ready for discharge from inpatient psychiatric care, and individuals residing in rural areas.	\$ 6,727,829
Total Treatment			\$ 7,881,171
Recovery Support Services			
Project #	Project Title	Project Description	Proposed Budget

Project #: BGCE-RSS1	Participant Support Funds- Housing and Recovery through Peer Services (HARPS) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$ 50,000
Project #: BGCE-RSS2	Participant Support Funds- Projects for Assistance in Transition from Homelessness (PATH) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$ 140,000
Project #: BGCE-RSS3	Participant support Funds - Peer Bridger	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$ 100,000
Project #: BGCE-RSS7	Certified Peer Counselor (CPC) Online Continuing Education Bank	Create online Certified Peer Counselor (CPC) continuing education trainings.	\$ 50,000
Project #: BGCE-RSS8	Foundational Community Support Supported Housing/Supported Employment (SH/SE) 'fidelity reviewer certification'	Creating a Supported Housing (SH) fidelity certification development/Individual Placement and Support (IPS) certification through Westat.	\$ 50,000
Project #: BGCE-RSS9	Community Work Incentive Coordinator (CWIC) training and staffing costs for a provider to attend the training	Scholarships for Foundational Community Support service providers to become Community Work Incentive Coordinator (CWIC) trained - https://vcu-ntdc.org/training/introductory/introindex.cfm	\$ 50,000
Project #: BGCE-RSS10	Intentional Peer Support Training	Train Certified Peer Counselors in Intentional Peer Support.	\$ 150,000
Project #: BGCE-RSS12	Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams	Targeted peer outreach on Project for Assistance in Transition from Homelessness (PATH) teams focusing on a by-name list of individuals who have had multiple contacts with crisis system.	\$ 1,120,000

Project #: BGCE-RSS13	Creating a Behavioral Health (BH) Housing Action plan	Inventory of all the housing needs of the Behavioral Health (BH) population.	\$	15,000
Project #: BGCE-RSS14	Creating a housing inventory/estimator/calculator	Provide timely information for individuals with behavioral health conditions to access housing services and resources.	\$	150,000
Project #: BGCE-RSS15	Peer Dashboard	Extract data out of the peer credential data system to have a dashboard.	\$	100,000
Project #: BGCE-RSS17	White paper/Toolkits/Medicaid Academy for Peer Run-Peer Operated Agencies	Creating a white paper on Community Behavioral Health Associate (CBHA) Lite licensing.	\$	15,000
Project #: BGCE-RSS18	Foundational Community Support - Converting Current Training to Online Training Modules	Convert Foundational Community Support training to online training modules.	\$	50,000
Project #: BGCE-RSS19	Cover Foundational Community Support Services in Institution for Mental Disease (IMD) when Medicaid is Suspended	Utilize block grant funds that would cover Foundational Community Support services for people transitioning out of Institution for Mental Disease (IMD) settings if Medicaid does not get retroactively reconnected.	\$	260,000
Project #: BGCE-RSS20	Peer Wellness Coach Training	Peer Wellness Coach continuing education curriculum developed.	\$	15,000
Project #: BGCE-RSS22	Training for Oxford Outreach Staff	De-escalation, mediation, basic grief counseling training for 10 Oxford outreach staff.	\$	20,000
Project #: BGCE-RSS23	Participant Engagement Kits for Youth - Mockingbird	Mental Health Block Grant (MHBG) & Substance Abuse Block Grant (SABG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	35,000

Project #: BGCE- RSS32	Operationalizing Peer Bridger	Create an operationalizing Peer Bridger program for hospitals, Substance Use Disorder (SUD), and Treatment (TX) agencies.	\$ 25,000
Project #: BGCE- RSS33	Create a Dashboard on Healthcare for Workers with Disabilities (HWD)	Public facing dashboard/Marketing on the number of people using the Medicaid buy-in program.	\$ 100,000
Project #: BGCE- RSS35	Implicit Biased Training for Landlords	Braid funding with Commerce to create a training for landlords.	\$ 10,000
Project #: BGCE- RSS36	Funding for SSI/SSDI Outreach, Access, and Recovery (SOAR) Leads	Helping individuals with the creation of a Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) outreach access and recovery community coordinators.	\$ 500,000
Project #: BGCE- RSS38	Rent Assistance	Housing subsidy funds, first/last deposits.	\$ 2,761,712
Total Recovery Support Services			\$ 5,766,712
Tribal			
Project #	Project Title	Project Description	Proposed Budget
Project #: BGCE- TRB3	Grants to Tribes and Urban Indian Health Organizations	Provide grants to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver Substance Use Disorder (SUD) prevention, treatment, Opioid Use Disorder (OUD) intervention and recovery support services within their Tribal communities.	\$ 861,119
Project #: BGCE- TRB4	Traditional Healing Pilot Project	Indian Health Care Provider (IHCP) to offer traditional healing/traditional Indian medicine (TIM) services and analyze the health outcomes and potential cost savings from offering Traditional Indian Medicine (TIM) services.	\$ 100,000
Total Tribal			\$ 961,119
Crisis Set-Aside			
Project #	Project Title	Project Description	Proposed Budget

Project #:	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding - Crisis Services	Services include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responders (DCR) services.	\$	1,345,566
Total Crisis Set-Aside			\$	1,345,566
TOTAL SABG Covid Supplement Budget				
FEP Set-Aside			\$	2,306,685
Treatment			\$	7,881,171
Recovery Supports Services			\$	5,766,712
Tribal			\$	961,119
Crisis Set-Aside			\$	1,345,566
Administrative			\$	961,119
Total Budget			\$	19,222,372

First Episode Psychosis Project Detail

Project #: BGCE-CYF4

Project Title: Early Identification and Intervention for Psychosis

Proposed Budget: \$2,306,685

Scope:

New Journeys Coordinated Specialty Care (CSC) provides outreach and intervention for transition-aged youth, young adults and their families when first experiencing symptoms psychosis. Members of the New Journeys treatment team will travel to the home, school, or elsewhere in the community to provide assessment, screening, and behavioral health services for individuals and families affected by first episode psychosis.

In 2019, the Washington State Legislature passed Second Substitute Senate Bill (2SSB) 5903, which requires the Health Care Authority (HCA) to submit a statewide plan, outlining the strategic implementation of Coordinated Specialty Care (CSC) programs first episode psychosis (FEP). The statewide plan vision is to have an adequate number of CSC teams, based on incidence and population,

across Washington by December 31, 2023. As of March 2021, there are 11 New Journeys Coordinated Specialty Care (CSC) teams in 9 regions across Washington State.

This additional project amount would support the continued state-wide roll-out and infrastructure development while work to get a case rate in place is completed.

In State Fiscal Year 2018 (SFY18) Research and Data Analysis (RDA) identified 1,698 Medicaid enrollees between the ages of 15 and 40 in Washington who received their first psychotic diagnosis. The number is likely to be a conservative estimate of the incidence of first episode psychosis because on average, people endure new psychotic symptoms for many months, and sometimes even years before receiving any psychiatric treatment for their disorder (Häfner et al., 2003; Perkins et al., 2005).

The longer a person goes untreated, the more severe and chronic their symptoms become, often resulting in decreased functioning and other negative outcomes over their lifetime.

Only 1% in the general population have schizophrenia, but over 30% of all spending for mental health treatment in the U.S. was accounted for by schizophrenia—about \$34 billion in 2001 (Mark et al., 2005). The high cost of treating schizophrenia is only one dimension of the impact of the illness, which has major effects on individuals, families, and society. The toll of schizophrenia arising from premature death, family caregiving, unemployment, criminal justice costs, and physical and emotional distress is striking (Samnaliev & Clark, 2008). According to the World Health Organization (Murray & Lopez, 1996), the combined economic and social costs of schizophrenia place it among the world's top ten causes of disability worldwide. Considering the magnitude of the impact of schizophrenia, interventions designed to treat the disorder effectively at the earliest possible point (e.g., during the first episode of psychosis) have the potential to improve its long-term trajectory, and to reduce the global burden of the illness.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Washington State Legislature, Children's & Youth Behavioral Health work group (CYBWHG) and SAMSHA have all prioritized early identification and intervention for psychosis. This is so screening and early identification of psychosis among adolescents and young adults will become a universal health care practice, and evidence-based recovery interventions will be available to those who need them.

New Journeys Coordinated Specialty Care (CSC) Team embraces services that are usually not provided with regular outpatient services. Members of the New Journeys treatment team will travel to the home, school, or elsewhere in the community to provide assessment, screening, and behavioral health services for individuals and families affected by first episode psychosis.

New Journeys is strength-based, meaning that treatment does not focus on the severity or persistence of psychiatric symptoms, but rather on how to help a person to get back on track with their life. This may look like help to return to school, start college, or seek employment. It may also mean helping a person achieve independent living or whatever goal they identify to help them experience a rewarding and meaningful life.

Treatment Projects Detail

Children, Youth and Family

Project #: BGCE-CYF2

Project Title: Developing WISE Workforce Support

Proposed Budget: \$200,000

Scope:

Developing Workforce & Enhancing Local Care Networks to support Youth with Intellectual or Developmental Disabilities including Autism Spectrum Disorder

Three lead Wraparound and Intensive Services (WISE) behavioral health agencies will plan and implement the project informed by local needs with logistical oversight provided the Wraparound and Intensive Services (WISE) Workforce Collaborative/En Route. A training component will be provided by Seattle Children's Autism Center and offered to a total of five (5) Behavioral Health agencies. The proposed RUBI training model will include:

- (1) An initial 16-hour workshop attended by all WISE team providers;
- (2) 20 weeks of ongoing consultation with the WISE team mental health therapist
- (3) Fidelity review of WISE therapist implementation of RUBI sessions

Agencies selected will have been involved in the Health Care Authority and Developmental Disabilities Administration (DDA) convened Wraparound and Intensive Services (WISE) and Intellectual Disabilities/Developmental Disabilities (ID/DD) and Autism Spectrum Disorder (ASD) workgroup or Project Echo sessions. This allows the project to build more directly on the knowledge and efforts already in process.

The three lead agencies will dedicate a portion of a staff time to participate in developing the specialty team model, attend training, learning collaboratives and consultation. Lead sites will also convene community partners to plan for enhancing their local care network to support youth with Intellectual Disabilities/Developmental Disabilities (ID/DD) and Autism Spectrum Disorder (ASD).

Addressing State Needs and Gaps, Including Gaps in Equity:

During COVID the increased need of trained staff to provide stabilization support for youth in Wraparound and Intensive Services (WISE) with Intellectual Disabilities/Developmental Disabilities (ID/DD) including Autism Spectrum Disorder (ASD) has become apparent. The concern identifying the

need for additional training has been expressed by caregivers, behavioral health agency staff and allied system partners. Our behavioral health workforce is often times generalists by education and don't have the training to best support youth with Autism Spectrum Disorder (ASD) and their families. This funding would provide the training support and consultation to five behavioral health agencies as well as enhance community coordination in three regions for youth enrolled in Wraparound and Intensive Services (WISe) with Intellectual Disabilities/Developmental Disabilities including Autism Spectrum Disorder.

The community coordination and development of this project would include outreach to BIPOC communities to participate and provide insight to specific community needs.

Project #: BGCE-CYF5

Project Title: Trauma Focused Cognitive Behavioral Therapy Training **Proposed Budget:** \$376,671

Scope:

Provide training in Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) to clinicians serving children and youth returning to school as part of the triage process post screening as a part of the recommended Department of Health fast response plan to help meet the needs of children and youth returning to school following the Governor's proclamation that in person options are required as of April 1, 2021. This will serve youth who indicate trauma exposure in the screening process (SED). This is following the Sonoma model, and will further enhance the clinical interventions available to children and youth across WA in the long run.

The Governor issued a proclamation that in person options be available across WA as of April 1, 2021. The potentially unmet needs of children and youth over the past year regarding mental health impact are expected to surface as children youth and families begin the transition to in person education. This proposal meets an identified need in the plans to date that matches the requirements of this funding.

Addressing State Needs and Gaps, Including Gaps in Equity:

The workforce serving children youth and families across Washington are dedicated to the age group and the developmentally appropriate interventions needed. This training further supports them in an evidence-based response to the expected wave of trauma exposure from impacts of the pandemic, to support and serve with resilience and strength-based approaches and supports in pushing back compassion fatigue in ensuring they have the tools they need to feel effective in their work, resulting in resilient communities.

Efforts will be made to ensure training is offered to diverse clinician groups including BIPOC and LGBTQ+ clinician groups.

Adult Treatment

Project #: BGCE-MHA1

Project Title: Cognitive Behavioral Therapy for Psychosis

Proposed Budget: \$130,000

Scope:

This project will expand upon our current contract with the University of Washington's Supporting Psychosis Innovation through Research, Implementation and Training (SPIRIT) Lab to deliver Cognitive Behavioral Therapy for Psychosis to a cohort of clinicians from selected contracted community-based sites who are serving people on 90/180 involuntary civil commitment orders. This Evidence Based Program (EBP) helps people living with psychosis achieve a level of self-management that has shown great success, supporting individuals and their families as they discharge back to the community. Many of the people on these long-term involuntary commitments experience psychosis so this Evidence Based Program is a good fit for the needs of this population. The plan is to first train the clinicians to a level of competency such that they then can be trained to supervise others with the model. It would then broaden to be delivered in group treatment and then be the model of treatment across the milieu. We believe that this implementation plan should have good sustainability for these sites.

Training contracted long term civil commitment sites in an appropriate Evidence Based Program should assist this population in better managing their symptoms and reduce their need for further involuntary or inpatient treatment. This recovery-based model supports both the individual and their family which should help individuals to successfully remain in the community.

Addressing State Needs and Gaps, Including Gaps in Equity:

Training our Behavioral Health workforce in Cognitive Behavioral Therapy (CBT) for Psychosis will help empower individuals living with psychosis to better manage symptoms that interfere with their ability to live their lives in the community. The Behavioral Health workforce needs enhanced tools to treat psychosis beyond simply medication alone. This evidence-based practice is targeted to the needs of a population that traditionally does not receive therapy as many clinicians do not know about Cognitive Based Therapy (CBT) for Psychosis and its success rate. Additionally, the facilities that have begun to take individuals on long term orders have reported a need for more enhanced programming for this population.

People living with psychosis experience much social isolation due to their symptoms. By providing them with greater skills to manage psychosis, this inequity will be better addressed. This enhancement will serve all populations living with psychosis, including members of BIPOC communities but is not a targeted outreach to them specifically.

Project #: BGCE-MHA2

Project Title: Trauma Informed Care for Designated Crisis Responders **Proposed Budget:** \$50,000

Scope:

Modify curriculum of Trauma Informed Care Training specifically for Designate Crisis Responders so that Designated Crisis Responders (DCR) can incorporate the skills into their practice. Conducting involuntary treatment investigations can be innately traumatizing. Incorporating trauma informed techniques into the Designative Crisis Responder (DCR) skill set can help make the investigations less traumatizing, and hopefully minimize long term trauma from the involuntary treatment process.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently no trauma informed care training specific to the work Designative Crisis Responders do. Involuntary Treatment Act (ITA) evaluations can be traumatizing for the people performing the evaluation. To minimize the impact to the Designated Crisis Responders, the individuals being evaluated and the system as a whole, this training is immediately necessary.

Individuals in BIPOC communities and those with serious behavioral health issues are more likely to have encounters with law and healthcare systems that result in furthering trauma. The trauma that effects the individual being evaluated also impacts the person doing the evaluation. Proper training can help improve the interactions between Designated Crisis Responders, law enforcement and individuals receiving treatment. This will assist in more sustainable recovery for every individual, and a system prepared to support those in need.

Project #: BGCE-MHA3

Project Title: Mental Health Specialist Training

Proposed Budget: \$396,671

Scope:

Develop curricula for a 100-hour course for Mental Health Professionals to secure credential to become an Older Adult Mental Health Specialist, Intellectual Disabilities/Developmental Disabilities (ID/DD) Mental Health Specialist, and Ethnic Minority Mental Health Specialist as defined in Washington's Rehab State Plan for Mental Health Outpatient (OP) treatment. Training curricula will focus on recognizing unique needs of these populations, clinical best practices, understanding of the community resources and partners when working with these populations, the role of Mental Health Specialist and how to provide clinical consultation, cultural humility, and other relevant information specific to each demographic.

The Division of Behavioral Health and Recovery (DBHR) has not sponsored Mental Health Specialists academies for almost ten years and as such, there are significant workforce shortages in specialists trained and credentialed to work with the older adult population, individuals with intellectual and developmental disabilities, and ethnic minorities. Each of these populations has unique needs or considerations that impact care and the behavioral health workforce needs additional training and supports in order to meet their needs.

Addressing State Needs and Gaps, Including Gaps in Equity:

With a fast-growing aging population, the need for mental health professionals trained and sufficiently skilled to work with older adult population is more critical than ever. The current workforce requires specialized skills and knowledge to better support BIPOC populations and people with Intellectual Disabilities/Developmental Disabilities. This is a work force shortage that must be addressed.

BIPOC communities, older adults, and people with Intellectual Disabilities/Developmental Disabilities must receive culturally appropriate services from clinicians with relevant education, experience, and skills. This is a matter of equity and parity.

BH-ASO Treatment Funding

Project #: BGCE-ASO2

Project Title: Behavioral Health Administrative Services Organization (BH-ASO) Treatment Funding
Proposed Budget: \$6,727,830

Scope:

Funding directed to the Behavioral Health Administrative Services Organizations (BH-ASO) will support their respective provider networks enhancing the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. This includes a regionally based system of care that includes mental health services to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities. Including increasing capacity of Designated Crisis Responder (DCR) and Tribal Designated Crisis Responder (DCR) services.

The community mental health services provided include but are not limited to outpatient services, including specialized outpatient services for American Indian/Alaskan Native (AI/AN), children, the elderly, individuals with a serious mental illness, residents of the service areas who have been discharged from inpatient treatment at a mental health facility, day treatment or other partial hospitalization services, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, or ready for discharge from inpatient psychiatric care, and individuals residing in rural areas. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retainment issues that have increased throughout the behavioral health delivery system during the pandemic.

If funding were not approved the statewide behavioral health service delivery system will continue to face funding gaps, service delivery delays and individuals diagnosed with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) will be less likely to have opportunities to function better in their communities and experience an improved quality of life. Further, an opportunity to enhance and improve ongoing behavioral health system workforce recruitment and staff retention worsened by the pandemic will be missed.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that policies and procedures have had different negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation.

Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based behavioral health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments.

Recovery Support Services Projects Detail

Project #: BGCE-RSS1

Project Title: Participant Support Funds – Housing and Recovery through Peer Services (HARPS) Teams
Proposed Budget: \$50,000

*Additional \$50,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

We expect the housing crisis and behavioral health crisis to intensify as eviction protections are lifted. The Housing and Recovery through Peer Support (HARPS) priority population is unable to earn wages while involved with inpatient treatment and is unlikely to have savings to secure housing upon discharge. Additionally, many participate intensive outpatient treatment which limits the amount of time to earn wages to afford housing, as well as other necessities to stay engaged in treatment and recovery activities.

Adding additional support funds to each Housing and Recovery through Peer Services (HARPS) contract to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination of other healthcare services and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Participant Support Funds will help the Housing and Recovery through Peer Support (HARPS) Teams to interweave care coordination, case management, and outreach services. People experiencing homelessness and behavioral health conditions benefit from connections to peer services and resources.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS2

Project Title: Participant Support Funds – Projects for Assistance in Transition from Homelessness (PATH) Teams
Proposed Budget: \$140,000

Scope:

Proposed support service funds will be added to the current contracted programs, Projects for Assistance in Transition from Homelessness (PATH). PATH programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency will be required to develop a detailed plan describing method and intended outcome for allocating client support service funding and submit to the Health Care Authority for approval by 09/30/2021. Plan must be based on Mental Health Block Grant (MHBG) guidance for Target Population* and Statement of Work.

Persistent and consistent outreach and providing services at the individual's pace are important steps to engage people with serious mental illness who are homeless. The proposed support service funds will enhance the quality of program delivery and engagement and expand critical client resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

Homeless outreach services intention is to reach individuals who are not currently engaged in services and potentially unable to navigate the system. The ability to have support services that offer basic needs upon engagement increases the likelihood for engagement in treatment and recovery.

PATH teams serve individuals experiencing homelessness and Serious Mental Illness (SMI) to BIPOC communities. BIPOC communities are overrepresented in homelessness. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: BGCE-RSS3

Project Title: Participant Support Funds – Peer Bridger
Proposed Budget: \$100,000

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).
- COVID-19 related expenses for those with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED), including testing and administering COVID vaccines, COVID awareness education, and purchase of Personal Protective Equipment (PPE).

Scope:

The goal of this project is to use participant funds to connect people to community supports and treatment and reduce recidivism to the state hospital admissions. Keeping individuals engaged in peer

services creates personal connection, accountability, and someone to assist in navigating complicated systems. Without these added supports the system continues to be a revolving door for many.

MHBG Funds could be used to support case managers, outreach workers, Assertive Community Treatment Services For people experiencing homelessness, medications, coordination with primary care, and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support improves engagement and increases hope by modeling recovery. These complimentary services will enhance the already proven Peer Bridger model.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS7

Project Title: Certified Peer Counselor (CPC) Online Continuing Education Bank

Proposed Budget: \$50,000

*Additional \$50,000 SABG

Scope:

This funding would be used to create online Certified Peer Counselor (CPC) continuing education trainings. The trainings could include Wellness Recovery Action Plans (WRAP), Crisis Plans, Suicide Prevention, cultural awareness, and others. The goal is to great online learning bank for Certified Peer Counselors where they can access continuing education trainings on demand.

These trainings would be accessible for all certified peer counselors in Washington and the knowledge gained will improved peer services provided in Washington. Traditionally Certified Peer Counselors (CPCs) continuing education trainings have been funded by DBHR, during the past year we have had to reallocate funding to meet the needs of the Certified Peer Counselor workforce by increasing our core Certified Peer Counselor (CPC) trainings. These online trainings will be able to be accessed by peers across the state no matter where they reside or work and removing barriers to access. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors (CPCs).

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors (CPCs) are effective in increasing recovery outcomes in mental health and Substance Use Disorder (SUD). Research shows peer support services improves engagement in increases hope by modeling recovery.

Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors. Continuing education for certified peer counselors is always requested and providing these trainings in a virtual format will make the trainings more accessible to peers in all areas of the state.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS8

Project Title: Foundational Community Support (FCS) Supported Housing/Supported Employment (SH/SE) Fidelity Reviewer Certification

Proposed Budget: \$50,000

*Additional \$50,000 SABG

Scope:

Intensive Trainings for Foundational Community Supports (FCS) providers to increase their skills/trainings on SAMSHA Permanent Supportive Housing (PSH) Fidelity Reviews and Individual Placement and Support (IPS) Support Employment Fidelity Reviews.

Washington State Foundational Community Support programs uses two evidence-based models- SAMSHA Permanent Supportive Housing and WESTAT/Rockville Institutes Individual Placement and Support Supported Employment Model. To ensure high quality standards and fidelity to these models, Foundational Community Support (FCS) providers participate in fidelity reviews. This funding will allow Foundational Community Support provider to participate in intensive training to able to provide high quality fidelity reviews and ensure compliance with the evidenced based practices.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal justice interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a

way out of poverty and prevent entry into the disability system. The Individual Placement and Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trials that demonstrated implementing Individual Placement and Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive employment as compared to individuals not receiving Individual Placement and Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement and Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

Foundational Community Supports utilizes the evidence-based practices of SAMSHA's Permanent Supportive Housing and Westat's individual placement and support. The principles of these evidence-based practices encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. These services also value and approach participants with equity, respect as well as cultural humility with the hope of promising outcomes.

Project #: BGCE-RSS9

Proposed Budget: \$50,000

Project Title: Community Work Incentive Coordinator (CWIC) Training and Staffing Costs

Scope:

Washington state Foundational Community Supports (FCS) supported employment providers serve individuals using the Evidence Based Practice of Individual Placement and Support, the program developed and managed by Westat Rockville Institute. Washington state legislature mandated the use of evidence based or promising practices when Foundational Community Support (FCS) was approved. The intent is for the service to be statewide and in order to positively impact sustainability, services should be provided to fidelity in order to achieve the greatest outcomes. An important element of the principles of Individual Placement and Support is the education of job seekers of how income may impact federal and state benefits and entitlements. There is currently not the bandwidth in Washington's State to provide work incentive education and planning to enroll individuals in the Foundational Community Support system. The proposal is to send Foundational Community Support (FCS) agency staff from agencies to enroll in webinars to learn the foundational knowledge of Social Security work incentives, and to secure certification training for select agency staff at behavioral health organizations in Western and Eastern Washington State. This initiative will greatly increase the number of benefit practitioners to education and support job seekers in the transition to competitive employment, attain self-sufficiency while decreasing reliance on public entitlement programs. The Institute on Employment and Disability in Cornell University's Industrial and Labor Relations School

training also has a credentialing option that provides a pathway to be recognized as an accredited work incentive planner. Work incentives pave the way to work and financial independence for recipients of public benefits. This training will provide essential insight into how the complex mix of work incentives, critically needed benefits, and earnings can be explained to an individual with a disability to encourage both work and financial independence.

There is a critical need for the training of benefit education planners in Washington State. The Foundational Community Support (FCS) program has 162 providers with 458 service location, with an enrollment of over 3,000 individuals. the availability of agency staff with foundational knowledge and access to certified benefit planners is crucial to provide support to enrolled participants and learn how earned income can impact entitlement benefits. These training opportunities will provide staff essential tools to assist job seekers to reach their individual goal of self-sufficiency. The implementation and practices of the Individual Placement Support (IPS) supported employment model are expanding in Washington State, and the critical need to adequately prepare agency staff of benefit planning curriculum is essential for overall long-term success. The certification training through the Institute on Employment and Disability in Cornell University's Industrial and Labor Relations School will prepare agency staff to support enrolled participants to develop a clear, comprehensive, and actionable report of an individual's financial situation and how to maximize self-sufficiency trends. There is not currently a more viable way to increase skills of agency staff and to increase the numbers of certified benefit planners.

Addressing State Needs and Gaps, Including Gaps in Equity:

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a way out of poverty and prevent entry into the disability system. The Individual Placement Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trails that demonstrated implementing Individual Placement Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive employment as compared to individuals not receiving Individual Placement Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

The Foundational Community Support Program is built upon evidenced based practices of SAMHSA and the Westat Rockville Institute to implement supported employment practices that are effective. The principles of these evidence-based practices (EBP) encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. The struggles of poverty and self-sufficiency negatively impact communities of people of color disproportionately. The implementation of based practices accelerates the positive impact on social

determinants of health in urban and rural communities. Services are provided are inclusive of all who need them and targeted to individuals with a wide range of disabilities.

Project #: BGCE-RSS10

Project Title: Intentional Peer Support Training

Proposed Budget: \$150,000

*Additional \$150,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

These funds will be used to train Certified Peer Counselors in Intentional Peer Support. These trainings will be provided either in person or in a virtual format depending on physical distancing requirements. Priority for these training will be Certified Peer Counselors (CPCs) who work on the following teams Peer Bridgers, Housing and Recovery through Peer Services (HARPS), Forensic Housing and Recovery through Peer Services (HARPS), Projects for Assistance in Transition from Homelessness (PATH), Forensic Projects for Assistance in Transition from Homelessness (PATH), Peer Pathfinders, and Foundational Community Support (FCS) teams. The training will be opened up to additional Certified Peer Counselors (CPCs) when space is available. This funding will also be used to provide travel supports for participants.

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors (CPCs) are effective in increasing recovery outcomes in mental health and Substance Use Disorder. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (EDI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS12

Proposed Budget: \$1,120,000

Project Title: Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disorder (SMI/SED).

Scope:

Proposed funds will add one peer counselor to each of the current Projects for Assistance in Transition from Homelessness (PATH). Project for Assistance in Transition from Homelessness (PATH) programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency will be required to hire and onboard a new peer counselor to expand outreach and engagement services for individuals with a serious mental illness (SMI) and homeless or at risk of homelessness. Projects will work closely with BHASO's, Managed Care Organization's (MCO's) and Crisis stabilization centers to create a referral flow and coordination of services.

The proposed expansion of adding one additional Projects for Assistance in Transition from Homelessness (PATH) peer counselor to each of the Projects for Assistance in Transition from Homelessness (PATH) teams will allow agencies to expand needed outreach and engagement efforts. The proposed funds will enhance the quality of program delivery and engagement and expand critical crisis resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

The intention of Homeless outreach services is to reach individuals who are not currently engaged in treatment, services and who are potentially unable to navigate the system. The ability to have one additional peer outreach team member will allow these programs to broaden the current outreach and engage services to a primary focus of crises response.

Projects for Assistance in Transition from Homelessness (PATH) teams currently serve individuals experiencing homelessness and mental illness and BIPOC communities. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: BGCE-RSS13

Project Title: Creating a Behavioral Health Housing Action Plan

Proposed Budget: \$15,000

*Additional \$15,000 SABG

Scope:

In 2007, the Mental Health State Transformation Initiative generated a Housing Action Plan. The Housing Action Plan conducted an inventory of affordable housing for people with serious mental illness, set a philosophical approach for Housing First principles and identified action steps to improve affordable housing. This proposal seeks to update the Housing Action Plan to include people with substance use disorders.

Washington is experiencing a significant housing crisis. Individuals with behavioral health conditions experience homelessness at a significant rate. The development of a housing action plan will create a north star for the behavioral health system to pursue partnerships to create and develop affordable housing.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will identify and analyze the needs and gaps for affordable housing for the behavioral health population. It will develop an action plan to meet the affordable housing needs of individuals with both mental health and substance use disorders.

The Behavioral Health Affordable Housing Action plan will analyze the impacts of homelessness on the BIPOC population. According to Research and Data Analysis, individuals experiencing homelessness are more likely to be African American or Alaska Native/American Indians (Ford-Shah, M., 2012)

Project #: BGCE-RSS14

Project Title: Creating a Housing Inventory/Estimator/Calculator

Proposed Budget: \$150,000

*Additional \$150,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Prison and jail re-entry and enhanced discharge from inpatient settings in order to reduce risks of COVID-19 transmission.

Scope:

The Research and Data Analysis Division (RDA) within the Department of Social and Health Services (DSHS) completed a series of reports in 2012 examining the housing status of individuals following their exit from institutional or out-of-home care settings. More than one-quarter of all five study populations (individuals leaving Substance Use Treatment Facilities; State Department of Corrections Facilities; Foster Care; State Mental Hospitals and Juvenile Rehabilitation Facilities) experienced homelessness at some point over a 12-month follow-up period. This project will create an online searchable tool based on various scenarios to connect individuals with behavioral health conditions to housing. Based on a

current algorithm currently housed in the Pathways to Employment Site, Research and Data Analysis will create a housing version for the Pathways to Housing site.

This searchable tool that will be housed on the Research and Data Analysis Pathways to Housing site will be used to help address the fact that almost 50 percent of Individuals leaving residential substance use treatment facilities became homeless within the year of discharge. Individuals exiting prison, foster care, State Mental Hospitals, and Juvenile Rehabilitation facilities were more likely to experience homelessness but as likely to obtain to permanent housing when they received housing assistance. Across the five study populations, the proportion of individuals in need of housing who received Homeless Management Information System (HIMS)-recorded assistance was highest for youth aging out of foster care (at 35 percent). Even though this report is dated, it is believed these relate to the population we intend to start with: individuals with behavioral health issues still exist and may even be more exacerbated with the COVID pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will provide timely information for individuals with behavioral health conditions to access housing services and resources.

The searchable housing tool will ensure individuals with Behavioral Health conditions and part of the BIPOC population will have access to housing services and resources.

Project #: BGCE-RSS15

Project Title: Peer Dashboard

Proposed Budget: \$100,000

*Additional \$100,000 SABG

Scope:

This funding would be used to create a Dashboard for the Peer Support Program. This would enable the team to see data pulled from the Peer Support database on an easily accessible format. There is increased focus on the peer support program to meet the growing workforce needs. This dashboard would allow the Health Care Authority to have immediate access to data for updates to lawmakers and stakeholders. Without the dashboard the Peer Support Team and leadership would not have easily accessible data about the Peer Support Program.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is a Behavioral Health workforce shortage in Washington and peer services are a growing workforce that can help to meet the Behavioral Health needs of our communities. The dashboard will allow the Division of Behavioral Health and Recovery easy access to data that could direct the Peer Support Program where to focus trainings where gaps are identified to increase the Certified Peer Counselor (CPC) workforce and the diversity of the Certified Peer Counselor workforce.

Programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all

programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS17

Proposed Budget: \$15,000
*Additional \$15,000 SABG

Project Title: White Paper/Toolkits/Medicaid Academy for Peer-Run Peer-Operated Agencies

Scope:

This funding would be used to create a white paper to explore strategies for peer run/peer operated agencies to become licensed community behavioral health agencies so that they will be able to bill Medicaid for peer services.

This would provide technical assistance for clubhouse and consumer run organizations to become licensed providers and bill Medicaid for peer services. This will increase recovery support services to a larger portion of the state. Washington State supports several clubhouse programs using general fund dollars and SB 5328 is proposing that the state go farther in helping clubhouses gain access to Medicaid funds. This project aligns with the bill to assist those organizations to bill Medicaid.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently a shortage of behavioral health workers across Washington State. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. This would allow additional agencies to become licensed to provide peer services increasing the availability of Mental Health and Substance Use Disorder (SUD) peer services to a larger population. If unfunded, this technical assistance will not be available in the state and could delay agencies in getting licensed to provided peer services.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS18

Proposed Budget: \$50,000

*Additional \$50,000 SABG

Project Title: Foundational Community Support (FCS) – Converting Current Training to Online Training Modules

Scope:

Foundational Community Supports (FCS) provides supported employment and supportive housing services across the state of Washington with over 160 agencies contracted to provide Foundational Community Support (FCS) services. The Division of Behavioral Health and Recovery (DBHR) has four full time trainers who provide technical assistance to Foundational Community Support (FCS) providers. The growth of Foundational Community Support (FCS) has increased the need for technical assistance/training and the Division of Behavioral Health and Recovery (DBHR) would like to convert some of the "stock" training that it provides to all new Foundational Community Support (FCS) providers to a virtual format. Creating online training modules of stock trainings currently provided in person will free up time for Foundational Community Support (FCS) trainers to provide more individualized, targeted, and intense technical assistance.

This project is critical to maintaining and improving the quality of services provided by Foundational Community Support (FCS) providers. Focused, targeted, and high-level training ensures consistency and adherence to the evidence-based modules that Foundational Community Support uses. Currently, the Division of Behavioral Health and Recovery Foundational Community Support trainers are spending much of their time delivering stock training to providers as they onboard new staff. This type of training could easily be provided in a virtual recorded format that would free up the Foundational Community Support (FCS) trainers time to provide more advanced targeted technical assistance to providers. Freeing up the Foundational Community Support (FCS) trainers time to focus on more targeted and nuanced technical assistance allows us to grow the quality of the Foundational Community Support program.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal justice interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a way out of poverty and prevent entry into the disability system. The Individual Placement Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trails that demonstrated implementing Individual Placement Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive

employment as compared to individuals not receiving Individual Placement Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

Foundational Community Supports utilizes the evidence-based practices of SAMSHA's Permanent Supportive Housing and Westat's individual placement and support. The principles of these evidence-based practices encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. These services also value and approach participants with equity, respect as well as cultural humility with the hope of promising outcomes.

Project #: BGCE-RSS19

Proposed Budget: \$260,000

*Additional \$500,000 SABG

Project Title: Cover Foundational Community Support (FCS) Services in Institution of Mental Disease (IMD) When Medicaid is Suspended

Scope:

The Division of Behavioral Health and Recovery proposes to utilize block grant funds to cover Foundational Community Support services for people transitioning out of Institution of Mental Disease (IMD) settings if the Medicaid isn't retroactively reconnected. The Foundational Community Support (FCS) program assists eligible individuals with complex health needs obtain and maintain stable housing and can provide Foundational Community Support services within short-term Institution of Mental Disease (IMD) settings with housing assessments and begin the housing acquisition process prior to discharge. These newly added services to Foundational Community Support will include coaching, advocacy, information and referral, linking and coordinating, and ongoing supports that they may not otherwise have access to.

The program offers an array of transition/pre-tenancy and tenancy-sustaining supports that have been effective in improving housing stability, health and employment outcomes for high need Medicaid beneficiaries. linking and coordinating, and ongoing supports that they may not otherwise have access to. Many of these individuals have complex health profiles and face multiple housing related barriers to effectively engaging with health care systems and managing their own plan of care to achieve improved health and wellness. Foundational Community Support have reduced the frequent use of emergency department and inpatient care, addressed significant gaps in connections to care, addressed homelessness, and now can help to facilitate timely, successful transitions from institutional settings to

integration in community placements. Anticipated Outcomes:

- Effectively target interventions to eligible individuals in residential treatment settings;
- Streamline and standardize transition and tenancy-sustaining services for individuals exiting residential treatment across agencies and systems;
- optimize and braid all available funding to fill gaps;
- reduce Substance Use Disorder/Opioid Use Disorder (SUD/OD) related deaths;
- improve Substance Use Disorder system capacity; and
- improve quality of care

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is no other mechanism to reimburse Foundational Community Support providers if the individuals Medicaid is not active at the time of authorization. The Health Care Authority has taken steps to attempt to mitigate this by providing Foundational Community Support providers access to Provider One to check Medicaid eligibility. This however is not a perfect solution and there are times when Foundational Community Support providers go unpaid.

The Foundational Community Support program is based on the evidence-based practices (EBP) of Permanent Supportive Housing (PSH) and Individual Placement and Support (IPS). The principles of these Evidence-Based Practices encompass equity and racial justice through the promotion of choice, flexible voluntary services, and access.

Project #: BGCE-RSS20

Project Title: Peer Wellness Coach Training

Proposed Budget: \$15,000
*Additional \$15,000 SABG

Scope:

These funds would be used to bring either [REDACTED] Wellness coaching or [REDACTED] Person Medicine Coach certification training to Certified Peer Counselors. [REDACTED] program can also bring a train the trainer to Washington so that we can training Certified Peer Counselors in Personal Medicine Coach training.

This project will provide continuing education to certified peer counselors in Washington State around. The intended outcome is to increase the knowledge of certified peer counselors to even more effectively support the peers they serve. Both programs focus on increased health outcomes. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors.

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors are effective in increasing recovery outcomes in mental health and Substance Use Disorder (SUD). Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors. This continued education will provide information to better support people in whole health as we are moving to a more integrated approach to who person care.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices, and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS22

Project Title: Training for Oxford Outreach Staff

Proposed Budget: \$20,000

*Additional \$20,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

We would like to add funding for training Oxford House Outreach Workers. There have been too many deaths in the Oxford Houses since COVID-19 started due to isolation and the feelings of hopelessness which brings an increase in drug and fentanyl use and ultimately relapses and deaths. Therefore, there is a need for the 10 Oxford House Outreach Representatives to get trainings on de-escalation, grief and loss, relapse prevention, meditation, Dialectical Behavioral Therapy (DBT), and any other training that would benefit the Oxford House Representatives in helping the residents deal with their grief, losses and fears of relapse.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Oxford House Sober Recovery Homes fills a gap in the substance use disorder services continuum by establishing and maintaining self-run, self-supported peer-operated sober recovery homes. In adherence with United States Code, Title 42, Section §300X–25 Group Homes for Recovering Substance Abusers, the State Agency will utilize the Oxford House concept to increase sober recovery housing assistance opportunities for recovering individuals living together in a residential disciplined environment to maintain recovery without recurrence of use. This level of care includes the provision of a safe and affordable home, in a drug-free living situation to recovering individuals with the support of other peers in recovery, Contractor staff, and other supports and services in the community including mental health guidance from outreach representatives who are trained.

Adult men and women completing residential treatment or are currently in outpatient treatment for substance use disorder, as well as those enrolled in recovery support, and opioid treatment services, who need a place to live and can meet the requirements for being a resident of a Recovery House. People leaving prisons and jails, Oxford House has a strong re-entry program with Department of Corrections (DOC) and does not discriminate on anyone's culture, race, or mores. Recovery housing will also include populations with a reported history of opioid use disorder (OUD) and opioid use.

Project #: BGCE-RSS23

Project Title: Participant Engagement Kits for Youth – Mockingbird

Proposed Budget: \$35,000

*Additional \$35,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

The Mockingbird Society creates, supports, and advocates for racially equitable, healthy environments that develop young people at risk of or experiencing foster care or homelessness. The Youth Advocates Ending Homelessness in Washington state report an alarming number of youth experience mental health, substance use disorders and health crisis. This includes advocates that report individuals who are experiencing medical issues that may or may not receive medical treatment. The inability to care for wounds will likely cause more server health issues or worse. Proposing funding for Mockingbird Outreach for Homeless Hygiene and wound care kits such as hand sanitizer, antiseptic, rubbing alcohol, hydrogen peroxide, ointment, band aids, gauze, and pain relievers could make the difference.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Mockingbird Society of Washington report Homeless youth lack access to medical care and often go without essential hygiene and wound care items which are not covered by Medicaid.

The Mockingbird Society creates, supports, and advocates for racially equitable, healthy environments that develop young people at risk of or experiencing foster care or homelessness.

Project #: BGCE-RSS32

Project Title: Operationalizing Peer Bridger

Proposed Budget: \$25,000

*Additional \$25,000 SABG

Scope:

This funding will be used to create an Operationalizing Peer Support training for the peer Bridger program for jails, hospitals and Substance Use Disorder (SUD) treatment agencies. Operationalizing Peer Support trainings provide Technical Assistance (TA) to existing and new agencies who need support with their peer program or who want to implement peer services. This training would also be to provide technical assistance to the jails, hospitals and inpatient setting who will be collaborating with the peer Bridger program.

As we transition the peer Bridger from providing services at the state hospitals into community-based hospitals and inpatient settings, technical assistance will be beneficial in the transition for the agencies, hospitals, and the peer Bridger program. If not approved, there will be confusion about the peer Bridger program and how to effectively utilize the services resulting in people not receiving these recovery support services. This could increase recidivism into an inpatient setting.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently a shortage of behavioral health workers across Washington State. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. We are currently witnessing gaps in service since the 90/180-day beds went live last year. This needed TA would be able to provide the necessary support and education to effectively utilize the peer Bridger program increasing recovery supports in inpatient settings.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS33

Proposed Budget: \$100,000

Project Title: Create a Dashboard on Healthcare for Workers with Disabilities

Scope:

The Apple Health for Workers with Disabilities (HWD) program recognizes the employment potential of people with disabilities and represents Washington State's response to the landmark "Ticket to Work" legislation passed by Congress in 1999. Healthcare for Workers with Disabilities (HWD) is an underutilized program within the state of Washington. This is a critical program to provide low-cost healthcare for people with disabilities, enabling people with disabilities to no longer have to choose between taking a job and having health care, and therefore work to their full potential. Marketing needs to include the message that self-sufficiency is attainable. There is a need to communicate measurements of number of individuals using the service as a part of marketing the program. This proposal is to develop a public facing dashboard as a part of marketing. There will be collaboration between the Health Care Authority departments that have Healthcare for Workers with Disabilities (HWD) as part of the service provided, with the communications department, and with Research and Data Analysis in order to come up with an attractive and fully functioning site that provides current and accurate data.

The benefit to the government is shifting individuals off of benefits and having them add to tax revenue. Under Healthcare for Workers with Disabilities, people with disabilities can earn more money and purchase health care coverage for an amount based on a sliding income scale.

Healthcare for Workers with Disabilities benefits include:

- Medicaid benefit package
- Access to long term services and supports, if functional requirements are met

- Greater personal and financial independence
- Members can earn and save more without the risk of losing their healthcare coverage

If not approved, people with disabilities have less encouragement to work and continue to live below the poverty level while remaining on public benefits. It disproportionately negatively impacts ethnic minorities.

Addressing State Needs and Gaps, Including Gaps in Equity:

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery, but many avoid seeking work due to fear of losing benefits. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Results from regressions on earnings suggest that Healthcare for Workers with Disabilities (HWD) participants with prior Medicaid coverage earn substantially more than non-participants in the year following enrollment. On average, they earn roughly \$2,000 more than their contemporary peers in the following year and \$2,500 more than a historical comparison group. Healthcare for Workers with Disabilities (HWD) Participants historically rely less on Basic Food benefits.

Healthcare for Workers with Disabilities (HWD) will create and sustain a culture of respect, caring and inclusion through employment. Programs that focus on employment enhance the value and respect garnered by the individual and help them to sustain their culture in the community. It empowers them to become positive role models. Services provided are inclusive of all who need them and targeted to individuals with a range of disabilities that have become successfully employed. Outreach will address the foregoing population.

Project #: BGCE-RSS35

Project Title: Implicit Biased Training for Landlords

Proposed Budget: \$10,000

*Additional \$10,000 SABG

Scope:

This project would create a training series for landlords on Implicit Bias. Implicit bias describes our attitudes towards people or associates stereotypes with them without our conscious knowledge. Implicit Bias trainings are designed to exposed to people to their biases and provide tools to adjust automatic patterns of thinking and ultimate eliminate discriminatory behaviors.

The Division of Behavioral Health and Recovery would work in partnership with the Department of Commerce's Landlord Mitigation Project to provide training to landlords who often rent to individuals with behavioral health conditions. Training would focus on addressing and identifying implicit biases and how this could be unintendedly affecting their decision on who to rent to.

This project is important because Washington State has a serious deficit of safe and affordable housing. This means that rentals are extremely scarce, and landlords could unintentionally discriminate against people of color and people with behavioral health conditions. The anticipated outcome of this project is to help landlords identify and then address their implicit biases.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal court interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

A disproportionate number of individuals of color experience housing instability. Many of these individuals experience significant barriers in accessing safe and affordable housing. WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. People with trauma, a history of homelessness, and co-occurring disorders have an increased likelihood of being involved in the criminal court system. This training will educate landlords on how their implicit bias might limit who they choose to rent to.

Project #: BGCE-RSS36

Proposed Budget: \$500,000

Project Title: Funding for SSI/SSDI, Outreach, Access, and Recovery (SOAR) Leads

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance.

Scope:

SSI/SSDI Outreach Access and Recovery (SOAR) is a proven effective model to increase access to governmental benefits. This project would create a SOAR Lead Position in multiple regions/counties (scalable). SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads hold local steering committee meetings, lead SSI/SSDI, Outreach, Access and Recovery (SOAR) online course training cohorts and conduct half-day SSI/SSDI, Outreach, Access and Recovery (SOAR) online course review sessions. SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads will also be mentoring individuals who complete the SSI/SSDI, Outreach, Access and Recovery (SOAR) online course and reporting on outcomes.

This will provide increased access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a serious mental illness. Access to these benefits will help individuals stabilize their housing and health.

Addressing State Needs and Gaps, Including Gaps in Equity:

Many unhoused individuals qualify for disability benefits but have a difficult time getting through the application process. With an SSI/SSDI, Outreach, Access Recovery (SOAR) Representative assisting with the application process, individuals are approved more often and more quickly. Most landlords require some kind of monthly income, this will help provide that and allow more individuals to obtain housing.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS38

Project Title: Rent Assistance

Proposed Budget: \$2,761,712

*Additional \$2,556,968 SABG

Scope:

Washington is experiencing a housing crisis. Individuals with behavioral health conditions are experiencing homelessness at significant rates. According to the 2020 Homeless Point in time Count, there are 10,814 unsheltered individuals on a single night in 2020. Dept. of Commerce manages the Point In time Count under federal requirements. According to the data, 4,743 individuals who identified with mental health conditions and 3,873 individuals who identified with substance use disorders were unsheltered.

Washington is experiencing a significant housing crisis. Individuals with behavioral health conditions experience homelessness at a significant rate. Rental Assistance will be crucial for meeting the housing needs of individuals with behavioral health conditions. The goal of this project is to reduce unsheltered homelessness of individuals with behavioral health conditions.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will identify and analyze the needs and gaps for affordable housing for the behavioral health population. It will develop an action plan to meet the affordable housing needs of individuals with both mental health and substance use disorders.

The Behavioral Health rental assistance program will ensure individuals from BIPOC populations receive rental assistance. According to Research and Data Analysis, individuals experiencing homelessness are more likely to be African American or Alaska Native/American Indians (Ford-Shah, M., 2012). According to the 2020 Point in time count, of the 10,814 individuals who were unsheltered on the day of the count, 36 percent were from BIPOC communities.

Targeted Housing Costs:

Total Proposed Funds for Targeted Housing: \$5,318,680
(\$2,556,968 SABG Covid Supplement and \$2,761,712 MHBG Covid Supplement)

Method for Determining Rental and Security Deposits: Fair Market Rents (FMRs) are used to determine payment standard amounts for the Housing Choice Voucher program, to determine initial renewal rents for some expiring project-based Section 8 contracts, to determine initial rents for housing assistance payment (HAP) contracts in the Moderate Rehabilitation Single Room Occupancy program (Mod Rehab), rent ceilings for rental units in both the HOME Investment Partnerships program and the Emergency Solution Grants program, calculation of maximum award amounts for Continuum of Care recipients and the maximum amount of rent a recipient may pay for property leased with Continuum of Care funds, and calculation of flat rents in Public Housing units.

Eligibility Criteria for Payment of Rent or Security Deposit: Individuals who are currently unsheltered and experiencing a behavioral health condition.

Proposed Procedures for Individuals to Request Rental Assistance: Behavioral Health Administrative Service Organizations (BH-ASO's) utilize their homeless outreach programs to identify individuals with behavioral health conditions currently unsheltered who need rental assistance.

Tribal Projects Detail

Project #: BGCE-TRB3

Project Title: Grants to Tribes and Urban Indian Health Organizations **Proposed Budget:** \$861,119
*Additional \$1,270,794 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Operation of an “access line,” “crisis phone line,” or “warm lines” to address any mental health issues for individuals.
- Training of staff and equipment that supports enhanced mental health crisis response and services.
- Mental Health Awareness training for first responders and others.
- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).
- Prison and jail re-entry and enhanced discharge from inpatient settings in order to reduce risks of COVID-19 transmission.
- COVID-19 related expenses for those with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED), including testing and administering COVID vaccines, COVID awareness education, and purchase of Personal Protective Equipment (PPE)

Scope:

The Health Care Authority will provide grants to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver needed substance use disorder prevention, treatment, Opioid Use Disorder (SUD) intervention and recovery supports services within their Tribal communities. Tribes would submit a plan to implement recommended services as outlined in the NOA and allowed within the Substance Abuse Block Grant/Mental Health Block Grant (SABG/MHBG) regulations. Additional Funds to Tribes \$40,993 SABG per Tribe and \$27,778 MHBG per Tribe, totaling \$68,771 for each Tribe.

This project is important because American Indian/Alaskan Native (AI/AN) and Tribal communities have been greatly affected by the COVID pandemic and the various Tribal and State Stay at Home Orders. Tribes are navigating how to operate Behavioral Health program in a virtual and semi/virtual environment. Due to the pandemic, Tribes are stating that the individuals in their communities are struggling with social isolation and a lack of treatment services due to the pandemic. There has also been limited cultural activities available for Tribal communities due to the pandemic. The historic annual Canoe Journey was canceled two years in a row with very limited ability to implement cultural programs across all Tribal communities.

Addressing State Needs and Gaps, Including Gaps in Equity:

Department of Health (DOH) reported that overdose rates have gone up over 154% during the first 6 months pandemic and is the highest of other communities by race/ethnicity. The statewide increase overall is 30%. The Health Care Authority needs to continue to provide resources to Tribal communities to address Substance Use Disorder and MHBG for American Indian/Alaskan Native (AI/AN) in WA. Providing direct grants to Tribes and Urban Indian Health Programs (UIHPs) also honors our government-to-government relationships by partnering with Tribes to serve American Indian/Alaskan Native WA State residents.

This project directly supports Diversity, Equity and Inclusion (DEI) by providing needed services to the American Indian/Alaskan Native (AI/AN) population in providing culturally appropriate services. This also honors our unique Government-to-Government (G2G) relationships with Tribal governments and our partnership with Urban Indian Health Programs (UIHPs).

Crisis Services:

Tribes and Urban Indian Health Programs (UIHPs) may provide crisis services with these funds. The Health Care Authority will pass down National Guidelines to Tribes to provide guidance on best practices for crisis services.

Project #: BGCE-TRB4

Project Title: Traditional Healing Pilot Project

Proposed Budget: \$100,000

*Additional \$100,000 SABG

Scope:

The Health Care Authority will contract with the Seattle Indian Health Board (SIHB) to (1) document best practices (including practice and administrative tools) for an Indian Health Care Provider (IHCP) to offer traditional healing/traditional Indian medicine (TIM) services, and (2) analyze the health outcomes and

potential cost savings from offering Traditional Indian Medicine (TIM) services. The Seattle Indian Health Board (SIHB) deliver the following to the Health Care Authority:

1. Recommendations for billing, coding and reimbursement models for Traditional Indian Medicine (TIM) services.
2. Analysis, recommendations, and examples of charting for Traditional Indian Medicine (TIM) services and incorporation of charting into an Electronic Health Record (EHR).
3. Recommendations and analysis on best practices for incorporating Traditional Indian Medicine (TIM) practitioners into integrated care teams.
4. Recommendation and analysis for privileging and credentialing standards of Traditional Indian Medicine (TIM) practitioners and apprentices.
5. Evaluation and analysis of the health outcomes for individuals and populations receiving the Traditional Indian Medicine (TIM) services. Measures could include:
 - Number of services completed;
 - Impacts on health outcomes;
 - Policy analysis;
 - Estimated costs of encounters;
 - Cost benefit analysis;
 - Comparison of the population that receives Traditional Indian Medicine (TIM) and the population that does not;
 - Comparison of patient's perception of their health pre-Traditional Indian Medicine (TIM) services and post-Traditional Indian Medicine (TIM) services, etc.

These items will be submitted as separate reports and guidance documents that will be available for the Health Care Authority, federal partners and other Indian Health Care Providers and Tribes in providing technical assistance on integrating Traditional Indian Medicine (TIM) into health programs with a focus on the prevention, treatment, and recovery of Substance Use Disorder and Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

The Washington Indian Health Care Improvement Act, passed by the state legislature in 2019, had three main goals:

1. Provide resources to ensure the highest possible health status of American Indians/Alaska Natives (AI/AN) in Washington;
2. Raise the health status of American Indian/Alaskan Native (AI/AN); and
3. Ensure tribal self-determination in the areas of health care services.

One recommendation coming out of the Act was the expansion of traditional Indian medicine (TIM). This project helps the Health Care Authority to honor this key recommendation. Traditional Indian Medicine (TIM) services provide unparalleled support for American Indian/Alaskan Natives individuals struggling with substance use disorder and/or severe mental illness or severe emotional disturbances and Western medicine has proven to not be appropriate for prevention, treatment and recovery supports for these American Indian/Alaskan Native (AI/AN) individuals. The anticipated outcome is documentation of positive health outcomes for individuals receiving Traditional Indian Medicine (TIM) and guidance to other Indian Health Care Providers (IHCP) on how to incorporate Traditional Indian Medicine (TIM). If not approved, we will continue to have a lack of literature available to demonstrate positive health outcomes or cost saving of these services for American Indian/Alaskan Native (AI/AN) and therefore, continue to struggle in finding sustainable funding.

Addressing State Needs and Gaps, Including Gaps in Equity:

The WA State Department of Health has found that American Indian/Alaska Native (AI/AN) overdose fatality rates have gone up 154% during the COVID pandemic. There is a known gap in the provision of culturally appropriate services for American Indian/Alaskan Natives (AI/AN) in the state of Washington and at a national level. Tribes and Indian Health Care Providers (IHCPs) are the experts in providing culturally appropriate services; however, Traditional Indian Medicine (TIM) does not have a sustainable funding mechanism. There are many evidence-based practices (EBP) available for Substance Use Disorder and Mental Health services; however, there are limited studies with American Indian/Alaskan Natives (AI/AN). Tribes and Indian Health Care Providers (IHCPs) find that implementing Evidence-Based Programs do not always work for American Indian/Alaskan Native (AI/AN) individuals and Tribal communities. This project will seek to develop evidence related to the efficacy of Traditional Indian Medicine (TIM) services for American Indian/Alaskan Natives (AI/AN) suffering from severe emotional disturbance, severe mental illness, or substance use disorder (SUD).

This project directly addresses Diversity, Equity and Inclusion (DEI) principles by providing support for Traditional Indian Medicine (TIM) and integration with clinically based health care. For decades, the response to Traditional Indian Medicine (TIM) is there is a lack of clinical data associating Traditional Indian Medicine (TIM) with better health outcomes. This pilot project will provide guidance around integration of Traditional Indian Medicine (TIM) and clinically based primary care and preliminary data to build the case for Traditional Indian Medicine (TIM). The intent is to provide foundational research and evidence that will support a request for sustainable Medicaid reimbursement for Traditional Indian Medicine (TIM).

Crisis Set-Aside Projects Detail

Project #: BGCE-ASO2

Proposed Budget: \$1,345,566

Project Title: Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding for Crisis Services

Scope:

Funding directed to the Behavioral Health Administrative Service Organizations (BH-ASO's) will support their respective provider networks enhancing the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. Funding will be used to enhance existing Crisis Services provided 24 hours a day, seven days a week including crisis call line, evaluation and treatment services for Individual's ineligible for Medicaid, including involuntary inpatient services, voluntary inpatient services, crisis stabilization services, Employment and Training (E&T) services, and services for the priority

populations defined per Contract. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retainment issues that have increased throughout the behavioral health delivery system during the pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that policies and procedures have had different negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation. Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based mental health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health and substance use crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments; and strategies to reduce the fragmentation of mental health care.

Washington

COVID-19 Supplemental Funding Plan for FY21

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

Center for Mental Health Services
Division of State and Community Systems Development

Mental Health Block Grant COVID Supplemental Funding Plan

WA State Summary

The COVID-19 pandemic has had a significant impact on people with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) in Washington State. During the first half of 2019, 8.2% of adults over 18 years of age had symptoms of anxiety disorder and 6.6% had symptoms of depressive disorder. By comparison, in the most recent Household Pulse Survey from the Centers for Disease Control examining trends from February 17, 2021 to March 1, 2021, this prevalence quadrupled to 33.4% for anxiety and 27.7% for depression (in Washington state, rates were slightly higher with 34.2% for anxiety, 14th highest of the 50 states, and 27.8% for depression, 23rd highest of the 50 states). The age group with the highest prevalence rates nationally is 18–29-year-olds (47.2% reporting anxiety, and 42.2% reporting depression). The devastating impacts of the COVID-19 pandemic have clearly impacted young adults' mental health and substance use (a population already at high risk).

As the state and nation emerge from early Phases of the pandemic, the resulting impacts of the last year are a salient concern. People face potentially new obstacles such as continued mental health issues, overcoming the potential disruptions in school, work, and finances, and re-engaging in social life with continued recommendations from the CDC and local health departments (e.g., mask mandates). This is a critical time to address potential harms and to encourage engagement in both adaptive coping behaviors and unique strategies of social engagement within current public health guidelines to reduce high-risk substance use and worsening mental health symptoms, in both adults and youth.

HCA's Division of Behavioral Health and Recovery has reviewed the *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* and allocated a percentage of the total potential COVID-19 relief supplemental funding to address principles focused on recovery needs, support for the behavioral health workforce, particularly of Peers and Recovery Support Peers, and trauma-informed treatment services. The budget summary, on the following pages, provides the detailed amounts allocated across the continuum of behavioral health services through a wide variety of projects, treatment funds provided through our Behavioral Health Administrative Service Organizations (BH-ASO's) and Tribes. WA Health Care Authority, with input from partners, including the Behavioral Health Advisory Council, respectfully submits the proposals you will find in the pages to follow.

As part of our effort to seek stakeholder input, the Behavioral Health Advisory Council co-hosted a meeting with the Health Care Authority to invite input from various partners and representatives from across the state's behavioral health system (from Peers to school districts, as well as counties, managed care organizations and others). Input on the proposals was received at the end of the event, which helped to inform the direction, as well as solidify the allocations to each section and confirm what flexibilities to seek within the application for these COVID-19 relief supplemental funds. In addition to waiver flexibilities, the Health Care Authority may also require some flexibility to move allocations from one proposal, to another, within those in this application, in the event a particular proposal is particularly successful and requires funding allocation from another proposal which may not require the entire allocation presented in this application.

Within the budget summary below, you will find the proposed project titles, a brief description and number for each project under the sections of First Episode Psychosis, Treatment, Recovery Support Services and Crisis Services. In the pages that follow, a longer project narrative will include the project title, budgeted amount, a description, or scope of work summary, as well as a narrative of how the project addresses state needs and gaps, especially gaps in equity.

WA is grateful to SAMHSA for the opportunity to apply for the COVID-19 relief supplemental funds, as this has been an unprecedented year of extreme stressors to the most vulnerable among us, and the funding will undoubtedly support those persons at greatest risk, as well as those who seek support in treatment and ongoing recovery.

Project List and Budget Table

FEP Set-Aside			
Project #	Project Title	Project Description	Proposed Budget
Project #: BGCE-CYF7	Rural and AI/AN Pilot Project for FEP	Develop and adapt evidence based coordinated specialty care programs for FEP to meet the needs of rural, frontier and AI/AN communities.	\$ 2,307,000
Total FEP Set-Aside			\$ 2,307,000
Treatment			
Children, Youth and Family Treatment Funding			
Project #	Project Title	Project Description	Proposed Budget
Project #: BGCE-CYF2	Developing Wraparound and Intensive Services (WISe) Workforce Support	Developing Wraparound and Intensive Service (WISe) workforce to support youth with Intellectual Disabilities/Developmental Disabilities (including Autism Spectrum Disorder (ASD)).	\$ 200,000
Project #: BGCE-CYF5	Trauma Focused Cognitive Behavioral Therapy Training	Trauma Focused Cognitive Behavioral Therapy (CBT) Training for clinicians serving children and youth returning to school as part of the triage process post screening.	\$ 376,671
Adult Treatment Funding			

Project #: BGCE- MHA1	Cognitive Behavioral Therapy for Psychosis	Expansion of current contract to deliver Cognitive Behavioral Therapy for Psychosis to a cohort of clinicians who are serving people on 90/180 involuntary civil commitment orders.	\$ 130,000
Project #: BGCE- MHA2	Trauma Informed Care for Designated Crisis Responders	Modify curriculum of Trauma Informed Care training specifically for Designated Crisis Responders to incorporate the skills into their practice.	\$ 50,000
Project #: BGCE- MHA3	Mental Health Specialist Training	Develop a curriculum for a 100-hour course for Mental Health (MH) professionals to secure credentials to become an Older Adult Mental Health Specialist, Intellectual Disabilities /Developmental Disabilities (ID/DD) Mental Health Specialist, and Ethnic Minority Mental Health Specialist.	\$ 396,329
BH-ASO Treatment Funding			
Project #: BGCE- ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding	The community mental health services provided include but are not limited to outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, residents of the service areas who have been discharged from inpatient treatment at a mental health facility, day treatment or other partial hospitalization services, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, or ready for discharge from inpatient psychiatric care, and individuals residing in rural areas.	\$ 6,150,372
Total Treatment			\$ 7,303,372
Recovery Support Services			
Project #	Project Title	Project Description	Proposed Budget

Project #: BGCE- RSS1	Participant Support Funds- Housing and Recovery through Peer Services (HARPS) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	50,000
Project #: BGCE- RSS2	Participant Support Funds- Projects for Assistance in Transition from Homelessness (PATH) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	140,000
Project #: BGCE- RSS3	Participant support Funds - Peer Bridger	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	100,000
Project #: BGCE- RSS7	Certified Peer Counselor (CPC) Online Continuing Education Bank	Create online Certified Peer Counselor (CPC) continuing education trainings.	\$	50,000
Project #: BGCE- RSS8	Foundational Community Support Supported Housing/Supported Employment (SH/SE) 'fidelity reviewer certification'	Creating a Supported Housing (SH) fidelity certification development/Individual Placement and Support (IPS) certification through Westat.	\$	50,000
Project #: BGCE- RSS9	Community Work Incentive Coordinator (CWIC) training and staffing costs for a provider to attend the training	Training for Foundational Community Support service providers to become Community Work Incentive Coordinator (CWIC) trained - https://vcu-ntdc.org/training/introductory/introindex.cfm	\$	50,000
Project #: BGCE- RSS10	Intentional Peer Support Training	Train Certified Peer Counselors in Intentional Peer Support.	\$	150,000
Project #: BGCE- RSS12	Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams	Targeted peer outreach on Project for Assistance in Transition from Homelessness (PATH) teams focusing on a by-name list of individuals who have had multiple contacts with crisis system.	\$	1,120,000

Project #: BGCE-RSS13	Creating a Behavioral Health (BH) Housing Action plan	Inventory of all the housing needs of the Behavioral Health (BH) population.	\$	15,000
Project #: BGCE-RSS14	Creating a housing inventory/estimator/calculator	Provide timely information for individuals with behavioral health conditions to access housing services and resources.	\$	150,000
Project #: BGCE-RSS15	Peer Dashboard	Extract data out of the peer credential data system to have a dashboard.	\$	100,000
Project #: BGCE-RSS17	White paper/Toolkits/Medicaid Academy for Peer Run-Peer Operated Agencies	Creating a white paper on Community Behavioral Health Associate (CBHA) Lite licensing.	\$	15,000
Project #: BGCE-RSS18	Foundational Community Support - Converting Current Training to Online Training Modules	Convert Foundational Community Support training to online training modules.	\$	50,000
Project #: BGCE-RSS19	Cover Foundational Community Support Services in Institution for Mental Disease (IMD) when Medicaid is Suspended	Utilize block grant funds that would cover Foundational Community Support services for people transitioning out of Institution for Mental Disease (IMD) settings if Medicaid does not get retroactively reconnected.	\$	500,000
Project #: BGCE-RSS20	Peer Wellness Coach Training	Peer Wellness Coach continuing education curriculum developed.	\$	15,000
Project #: BGCE-RSS22	Training for Oxford Outreach Staff	De-escalation, mediation, basic grief counseling training for 10 Oxford outreach staff.	\$	20,000
Project #: BGCE-RSS23	Participant Engagement Kits for Youth - Mockingbird	Mental Health Block Grant (MHBG) & Substance Abuse Block Grant (SABG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	35,000

BGCE-RSS24	Peer Pathfinders Transition from Incarceration Pilot	Enhance jail transition programs with SUD peers services to individuals who upon release will be homeless. SUD Peer Services begin prior to release to establish relationship and upon release to support the transition to needed services.	\$ 790,000
BGCE-RSS25	Add Co-Occurring Peer to Forensic-Housing Housing and Recovery through Peer (F-HARPS) Services	Add 1 peer to each of the four Forensic-Housing Housing and Recovery through Peer Services (F-HARPS) in Phase I regions.	\$ 400,000
Project #: BGCE-RSS32	Operationalizing Peer Bridger	Create an operationalizing Peer Bridger program for hospitals, Substance Use Disorder (SUD), and Treatment (TX) agencies.	\$ 25,000
Project #: BGCE-RSS33	Create a Dashboard on Healthcare for Workers with Disabilities (HWD)	Public facing dashboard/Marketing on the number of people using the Medicaid buy-in program.	\$ 100,000
Project #: BGCE-RSS35	Implicit Biased Training for Landlords	Braid funding with Commerce to create a training for landlords.	\$ 10,000
Project #: BGCE-RSS36	Funding for SSI/SSDI Outreach, Access, and Recovery (SOAR) Leads	Helping individuals with the creation of a Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) outreach access and recovery community coordinators.	\$ 500,000
BGCE-RSS41	Enhance Mobile Crisis Teams with CPCs	Pilot enhancements to mobile crisis teams by adding CPCs to existing teams.	\$ 1,909,000
Total Recovery Support Services			\$ 6,344,000
Tribal			
Project #	Project Title	Project Description	Proposed Budget

Project #:	BGCE-TRB3	Grants to Tribes and Urban Indian Health Organizations	Provide grants to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver Substance Use Disorder (SUD) prevention, treatment, Opioid Use Disorder (OUD) intervention and recovery support services within their Tribal communities.	\$	861,000
Project #:	BGCE-TRB4	Traditional Healing Pilot Project	Indian Health Care Provider (IHCP) to offer traditional healing/traditional Indian medicine (TIM) services and analyze the health outcomes and potential cost savings from offering Traditional Indian Medicine (TIM) services.	\$	100,000
Total Tribal				\$	961,119
Crisis Set-Aside					
Project #	Project Title	Project Description	Proposed Budget		
Project #:	BGCE-ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding - Crisis Services	Services include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responders (DCR) services.	\$	1,346,000
Total Crisis Set-Aside				\$	1,346,000
TOTAL SABG Covid Supplement Budget					
FEP Set-Aside				\$	2,307,000
Treatment				\$	7,303,372
Recovery Supports Services				\$	6,344,000
Tribal				\$	961,000
Crisis Set-Aside				\$	1,346,000
Administrative				\$	961,000
Total Budget				\$	19,222,372

First Episode Psychosis Project Detail

Project #: BGCE-CYF7

Project Title: Rural and AI/AN Pilot Project for FEP

Proposed Budget: \$2,307,000

Scope:

Develop and adapt evidence based coordinated specialty care (CSC) programs for first episode psychosis (FEP) to meet the needs of rural, frontier and AI/AN communities. The project would be to help to develop a rural and /or Tribal New Journeys/CSC model, to evaluate it, and broadly disseminate the results to inform future program development. Other states are also interested in figuring out how to develop CSC services in rural areas and Tribal communities. There could be great value in collaborating with partners in other states on this (they would fund their own program development) and could help to define rural and AI/AN CSC in other parts of the U.S.

This work is critical to accomplish the legislative mandate in SSSB 5903 requiring statewide expansion of treatment for FEP. Specialized knowledge and adaptation is essential to meet the unique needs of sparsely populated regions and minority communities in order to achieve the goal of decreasing the duration of untreated psychosis. Considering the magnitude of the impact of schizophrenia, interventions designed to treat the disorder effectively at the earliest possible point (e.g., during the first episode of psychosis) have the potential to improve its long-term trajectory, improve outcomes, improve lives, save lives and save health care dollars and to reduce the health care burden of the illness. The longer a person goes untreated, the more severe and chronic their symptoms become, often resulting in decreased functioning and other negative outcomes over their lifetime.

Addressing State Needs and Gaps, Including Gaps in Equity:

Initial examination of 2018 Medicaid data indicate that extra support is needed to ensure that intervention with first episode is equally available in rural geographical areas and in AI/AN communities. The data suggest there are existing geographical disparities and AI/AN disproportionality. The Washington State Legislature, Children's & Youth Behavioral Health work group (CYBWHG) and SAMSHA have all prioritized early identification and intervention for psychosis. This is so screening and early identification of psychosis among adolescents and young adults will become a universal health care practice, and evidence-based recovery interventions will be available to those who need them.

Treatment Projects Detail

Children, Youth and Family

Project #: BGCE-CYF2

Project Title: Developing WISE Workforce Support

Proposed Budget: \$200,000

Scope:

Developing Workforce & Enhancing Local Care Networks to support Youth with Intellectual or Developmental Disabilities including Autism Spectrum Disorder
Three lead Wraparound and Intensive Services (WISE) behavioral health agencies will plan and implement the project informed by local needs with logistical oversight provided the Wraparound and Intensive Services (WISE) Workforce Collaborative/En Route. A training component will be provided by Seattle Children's Autism Center and offered to a total of five (5) Behavioral Health agencies. The proposed RUBI training model will include:

- (1) An initial 16-hour workshop attended by all WISE team providers;
- (2) 20 weeks of ongoing consultation with the WISE team mental health therapist
- (3) Fidelity review of WISE therapist implementation of RUBI sessions

Agencies selected will have been involved in the Health Care Authority and Developmental Disabilities Administration (DDA) convened Wraparound and Intensive Services (WISE) and Intellectual Disabilities/Developmental Disabilities (ID/DD) and Autism Spectrum Disorder (ASD) workgroup or Project Echo sessions. This allows the project to build more directly on the knowledge and efforts already in process.

The three lead agencies will dedicate a portion of a staff time to participate in developing the specialty team model, attend training, learning collaboratives and consultation. Lead sites will also convene community partners to plan for enhancing their local care network to support youth with Intellectual Disabilities/Developmental Disabilities (ID/DD) and Autism Spectrum Disorder (ASD).

Addressing State Needs and Gaps, Including Gaps in Equity:

During COVID the increased need of trained staff to provide stabilization support for youth in Wraparound and Intensive Services (WISE) with Intellectual Disabilities/Developmental Disabilities (ID/DD) including Autism Spectrum Disorder (ASD) has become apparent. The concern identifying the need for additional training has been expressed by caregivers, behavioral health agency staff and allied system partners. Our behavioral health workforce is often times generalists by education and don't have the training to best support youth with Autism Spectrum Disorder (ASD) and their families. This funding would provide the training support and consultation to five behavioral health agencies as well as enhance community coordination in three regions for youth enrolled in Wraparound and Intensive Services (WISE) with Intellectual Disabilities/Developmental Disabilities including Autism Spectrum Disorder.

The community coordination and development of this project would include outreach to BIPOC communities to participate and provide insight to specific community needs.

Project #: BGCE-CYF5

Project Title: Trauma Focused Cognitive Behavioral Therapy Training **Proposed Budget:** \$376,671

Scope:

Provide training in Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) to clinicians serving children and youth returning to school as part of the triage process post screening as a part of the recommended Department of Health fast response plan to help meet the needs of children and youth returning to school following the Governor's proclamation that in person options are required as of April 1, 2021. This will serve youth who indicate trauma exposure in the screening process (SED). This is following the Sonoma model, and will further enhance the clinical interventions available to children and youth across WA in the long run.

The Governor issued a proclamation that in person options be available across WA as of April 1, 2021. The potentially unmet needs of children and youth over the past year regarding mental health impact are expected to surface as children youth and families begin the transition to in person education. This proposal meets an identified need in the plans to date that matches the requirements of this funding.

Addressing State Needs and Gaps, Including Gaps in Equity:

The workforce serving children youth and families across Washington are dedicated to the age group and the developmentally appropriate interventions needed. This training further supports them in an evidence-based response to the expected wave of trauma exposure from impacts of the pandemic, to support and serve with resilience and strength-based approaches and supports in pushing back compassion fatigue in ensuring they have the tools they need to feel effective in their work, resulting in resilient communities.

Efforts will be made to ensure training is offered to diverse clinician groups including BIPOC and LGBTQ+ clinician groups.

Adult Treatment

Project #: BGCE-MHA1

Project Title: Cognitive Behavioral Therapy for Psychosis **Proposed Budget:** \$130,000

Scope:

This project will expand upon our current contract with the University of Washington's Supporting Psychosis Innovation through Research, Implementation and Training (SPIRIT) Lab to deliver Cognitive Behavioral Therapy for Psychosis to a cohort of outpatient and inpatient clinicians from selected contracted community-based sites who are serving people receiving 90/180 involuntary civil commitment orders. This Evidence Based Practice (EBP) helps people living with psychosis achieve a level of self-management that has shown great success, supporting individuals and their families in the community.

Many of the people on these long-term involuntary commitments experience psychosis so this Evidence Based Practice is a good fit for the needs of this population. We will train two cohorts of clinicians- each cohort containing staff from an inpatient setting serving people on 90/180 involuntary civil commitment orders and a corresponding outpatient behavioral health agency that treats these individuals upon discharge- or may have treated the individual prior to admission. This will allow the skills learned in either setting to be supported and reinforced in the other setting. The plan is to first train the clinicians to a level of competency such that they then can be trained to supervise others with the model. It would then broaden to be delivered in group treatment and then be the model of treatment across the milieu for those in inpatient settings. We believe that this implementation plan should have good sustainability for these sites.

Training outpatient behavioral health agency staff and their locally corresponding contracted long term civil commitment sites in an appropriate Evidence Based Practice should assist this population in better managing their symptoms and reduce their need for further involuntary or inpatient treatment. This recovery-based model supports both the individual and their family which should help individuals to successfully remain in the community.

Addressing State Needs and Gaps, Including Gaps in Equity:

Training our Behavioral Health workforce in Cognitive Behavioral Therapy (CBT) for Psychosis will help empower individuals living with psychosis to better manage symptoms that interfere with their ability to live their lives in the community. The Behavioral Health workforce needs enhanced tools to treat psychosis beyond simply medication alone. This evidence-based practice is targeted to the needs of a population that traditionally does not receive therapy as many clinicians do not know about Cognitive Based Therapy (CBT) for Psychosis and its success rate. Additionally, the facilities that have begun to take individuals on long term orders have reported a need for more enhanced programming for this population and it is important to provide continuity of care, including support for skills development, across care settings.

People living with psychosis experience much social isolation due to their symptoms. By providing them with greater skills to manage psychosis, this inequity will be better addressed. This enhancement will serve all populations living with psychosis, including members of BIPOC communities but is not a targeted outreach to them specifically.

Project #: BGCE-MHA2

Project Title: Trauma Informed Care for Designated Crisis Responders **Proposed Budget:** \$50,000

Scope:

Modify curriculum of Trauma Informed Care Training specifically for Designate Crisis Responders so that Designated Crisis Responders (DCR) can incorporate the skills into their practice. Conducting involuntary treatment investigations can be innately traumatizing. Incorporating trauma informed techniques into the Designative Crisis Responder (DCR) skill set can help make the investigations less traumatizing, and hopefully minimize long term trauma from the involuntary treatment process.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently no trauma informed care training specific to the work Designative Crisis Responders do. Involuntary Treatment Act (ITA) evaluations can be traumatizing for the people performing the evaluation. To minimize the impact to the Designated Crisis Responders, the individuals being evaluated and the system as a whole, this training is immediately necessary.

Individuals in BIPOC communities and those with serious behavioral health issues are more likely to have encounters with law and healthcare systems that result in furthering trauma. The trauma that effects the individual being evaluated also impacts the person doing the evaluation. Proper training can help improve the interactions between Designated Crisis Responders, law enforcement and individuals receiving treatment. This will assist in more sustainable recovery for every individual, and a system prepared to support those in need.

Project #: BGCE-MHA3

Project Title: Mental Health Specialist Training

Proposed Budget: \$396,329

Scope:

Develop curricula for a 100-hour course for Mental Health Professionals who provide treatment services to individuals with SMI or SED to secure credential to become an Older Adult Mental Health Specialist, Intellectual Disabilities/Developmental Disabilities (ID/DD) Mental Health Specialist, and Ethnic Minority Mental Health Specialist as defined in Washington's Rehab State Plan for Mental Health Outpatient (OP) treatment. Training curricula will focus on recognizing unique needs of these populations, clinical best practices, understanding of the community resources and partners when working with these populations, the role of Mental Health Specialist and how to provide clinical consultation, cultural humility, and other relevant information specific to each demographic.

The Division of Behavioral Health and Recovery (DBHR) has not sponsored Mental Health Specialists academies for almost ten years and as such, there are significant workforce shortages in specialists trained and credentialed to work with the older adult population, individuals with intellectual and developmental disabilities, and ethnic minorities. Each of these populations has unique needs or considerations that impact care and the behavioral health workforce needs additional training and supports in order to meet their needs. The overall intent is to provide better care for clinicians who provide services to SMI and SED populations.

Addressing State Needs and Gaps, Including Gaps in Equity:

With a fast-growing aging population, the need for mental health professionals trained and sufficiently skilled to work with older adult population is more critical than ever. The current workforce requires specialized skills and knowledge to better support BIPOC populations and people with Intellectual Disabilities/Developmental Disabilities. This is a work force shortage that must be addressed.

BIPOC communities, older adults, and people with Intellectual Disabilities/Developmental Disabilities must receive culturally appropriate services from clinicians with relevant education, experience, and skills. This is a matter of equity and parity.

BH-ASO Treatment Funding

Project #: BGCE-ASO2

Project Title: Behavioral Health Administrative Services Organization (BH-ASO) Treatment Funding
Proposed Budget: \$6,150,372

Scope:

Funding directed to the Behavioral Health Administrative Services Organizations (BH-ASO) will support their respective provider networks enhancing the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. This includes a regionally based system of care that includes mental health services to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities. Including increasing capacity of Designated Crisis Responder (DCR) and Tribal Designated Crisis Responder (DCR) services.

The community mental health services are provided to individuals with serious mental illness/serious emotional disturbance including specialized outpatient services for American Indian/Alaskan Native (AI/AN), children, and the elderly. Services provided include but are not limited to outpatient services for individuals who have been **discharged** from inpatient treatment, day treatment, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, and individuals residing in rural areas. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retainment issues that have increased throughout the behavioral health delivery system during the pandemic.

If funding were not approved the statewide behavioral health service delivery system will continue to face funding gaps, service delivery delays, and individuals diagnosed with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) will be less likely to have opportunities to access services and function better in their communities experiencing an improved quality of life. Further, an opportunity to enhance and improve ongoing behavioral health system workforce recruitment and staff retention worsened by the pandemic will be missed.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support, and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that policies and procedures have had negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation.

Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based behavioral health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments.

Recovery Support Services Projects Detail

Project #: BGCE-RSS1

Project Title: Participant Support Funds – Housing and Recovery through Peer Services (HARPS) Teams
Proposed Budget: \$50,000

*Additional \$50,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice example. This project would provide funds directly related to benefit participants in the HARPS program to assist individuals who are transitioning from inpatient settings to the community. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

We expect the housing crisis and behavioral health crisis to intensify as eviction protections are lifted. The Housing and Recovery through Peer Support (HARPS) priority population is unable to earn wages while involved with inpatient treatment and is unlikely to have savings to secure housing upon discharge. Additionally, many participate intensive outpatient treatment which limits the amount of time to earn wages to afford housing, as well as other necessities to stay engaged in treatment and recovery activities.

Adding additional support funds to each Housing and Recovery through Peer Services (HARPS) contract to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination of other healthcare services and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Participant Support Funds will help the Housing and Recovery through Peer Support (HARPS) Teams to interweave care coordination, case management, and outreach services. People experiencing homelessness and behavioral health conditions benefit from connections to peer services and resources.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity

through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS2

Project Title: Participant Support Funds – Projects for Assistance in Transition from Homelessness (PATH) Teams
Proposed Budget: \$140,000

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice example. This project would provide funds directly related to benefit participants in the homeless outreach teams to assist individuals who are seriously mentally ill and not engaged in treatment. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

Proposed support service funds will be added to the current contracted programs, Projects for Assistance in Transition from Homelessness (PATH). PATH programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency will be required to develop a detailed plan describing method and intended outcome for allocating client support service funding and submit to the Health Care Authority for approval by 09/30/2021. Plan must be based on Mental Health Block Grant (MHBG) guidance for Target Population* and Statement of Work.

Persistent and consistent outreach and providing services at the individual's pace are important steps to engage people with serious mental illness who are homeless. The proposed support service funds will enhance the quality of program delivery and engagement and expand critical client resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

Homeless outreach services intention is to reach individuals who are not currently engaged in services and potentially unable to navigate the system. The ability to have support services that offer basic needs upon engagement increases the likelihood for engagement in treatment and recovery.

PATH teams serve individuals experiencing homelessness and Serious Mental Illness (SMI) to BIPOC communities. BIPOC communities are overrepresented in homelessness. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: BGCE-RSS3

Project Title: Participant Support Funds – Peer Bridger

Proposed Budget: \$100,000

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).
- COVID-19 related expenses for those with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED), including testing and administering COVID vaccines, COVID awareness education, and purchase of Personal Protective Equipment (PPE).

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice example. This project would provide funds directly related to benefit participants with serious mental illness who are transitioning from inpatient settings to the community. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

The goal of this project is to use participant funds to connect people to community supports and treatment and reduce recidivism to the state hospital admissions. Keeping individuals engaged in peer services creates personal connection, accountability, and someone to assist in navigating complicated systems. Without these added supports the system continues to be a revolving door for many.

MHBG Funds could be used to support case managers, outreach workers, Assertive Community Treatment Services For people experiencing homelessness, medications, coordination with primary care, and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support improves engagement and increases hope by modeling recovery. These complimentary services will enhance the already proven Peer Bridger model.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS7

Project Title: Certified Peer Counselor (CPC) Online Continuing Education Bank

Proposed Budget: \$50,000

*Additional \$50,000 SABG

Scope:

This funding would be used to create online Certified Peer Counselor (CPC) continuing education trainings. The trainings could include Wellness Recovery Action Plans (WRAP), Crisis Plans, Suicide Prevention, cultural awareness, and others. The goal is to great online learning bank for Certified Peer Counselors where they can access continuing education trainings on demand.

These trainings would be accessible for all certified peer counselors in Washington and the knowledge gained will improved peer services provided in Washington. Traditionally Certified Peer Counselors (CPCs) continuing education trainings have been funded by DBHR, during the past year we have had to reallocate funding to meet the needs of the Certified Peer Counselor workforce by increasing our core Certified Peer Counselor (CPC) trainings. These online trainings will be able to be accessed by peers across the state no matter where they reside or work and removing barriers to access. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors (CPCs).

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors (CPCs) are effective in increasing recovery outcomes in mental health and Substance Use Disorder (SUD). Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors. Continuing education for certified peer counselors is always requested and providing these trainings in a virtual format will make the trainings more accessible to peers in all areas of the state.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS8

Project Title: Foundational Community Support (FCS) Supported Housing/Supported Employment (SH/SE) Fidelity Reviewer Certification

Proposed Budget: \$50,000

*Additional \$50,000 SABG

Scope:

Intensive Trainings for Foundational Community Supports (FCS) providers to increase their skills/trainings on SAMSHA Permanent Supportive Housing (PSH) Fidelity Reviews and Individual Placement and Support (IPS) Support Employment Fidelity Reviews.

Washington State Foundational Community Support programs uses two evidence-based models- SAMSHA Permanent Supportive Housing and WESTAT/Rockville Institutes Individual Placement and Support Supported Employment Model. To ensure high quality standards and fidelity to these models, Foundational Community Support (FCS) providers participate in fidelity reviews. This funding will allow Foundational Community Support provider to participate in intensive training to able to provide high quality fidelity reviews and ensure compliance with the evidenced based practices.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal justice interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a way out of poverty and prevent entry into the disability system. The Individual Placement and Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trails that demonstrated implementing Individual Placement and Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive employment as compared to individuals not receiving Individual Placement and Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement and Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

Foundational Community Supports utilizes the evidence-based practices of SAMSHA's Permanent Supportive Housing and Westat's individual placement and support. The principles of these evidence-based practices encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. These services also value and approach participants with equity, respect as well as cultural humility with the hope of promising outcomes.

Project #: BGCE-RSS9

Proposed Budget: \$50,000

Project Title: Community Work Incentive Coordinator (CWIC) Training and Staffing Costs

Scope:

This project proposes to use MHBG funds to cover Staff training costs for community behavioral health agencies to become Community Work Incentive Coordinators. Nothing provides 'hope' more than believing that people can work but addressing an individual's concerns about how working affects their governmental benefits is key to implementing the evidence-based practice model called Individual Placement and Support. Benefits counseling is one of the core principles of providing this EBP model.

Washington State's Foundational Community Supports (FCS) supported employment providers serve individuals using the Evidence Based Practice of Individual Placement and Support, the program developed and managed by Westat Rockville Institute. Washington state legislature mandated the use of evidence based or promising practices when Foundational Community Support (FCS) was approved. The intent is for the service to be statewide and in order to positively impact sustainability, services should be provided to fidelity in order to achieve the greatest outcomes. An important element of the principles of Individual Placement and Support is the education of job seekers of how income may impact federal and state benefits and entitlements. There is currently not the bandwidth in Washington's State to provide work incentive education and planning to enroll individuals in the Foundational Community Support system. The proposal is to send Foundational Community Support (FCS) agency staff from agencies to enroll in webinars to learn the foundational knowledge of Social Security work incentives, and to secure certification training for select agency staff at behavioral health organizations in Western and Eastern Washington State. This initiative will greatly increase the number of benefit practitioners to education and support job seekers in the transition to competitive employment, attain self-sufficiency while decreasing reliance on public entitlement programs. The Institute on Employment and Disability in Cornell University's Industrial and Labor Relations School training also has a credentialing option that provides a pathway to be recognized as an accredited work incentive planner. Work incentives pave the way to work and financial independence for recipients of public benefits. This training will provide essential insight into how the complex mix of work incentives, critically needed benefits, and earnings can be explained to an individual with a disability to encourage both work and financial independence.

There is a critical need for the training of benefit education planners in Washington State. The Foundational Community Support (FCS) program has 162 providers with 458 service location, with an enrollment of over 3,000 individuals. the availability of agency staff with foundational knowledge and access to certified benefit planners is crucial to provide support to enrolled participants and learn how earned income can impact entitlement benefits. These training opportunities will provide staff essential tools to assist job seekers to reach their individual goal of self-sufficiency. The implementation and practices of the Individual Placement Support (IPS) supported employment model are expanding in Washington State, and the critical need to adequately prepare agency staff of benefit planning curriculum is essential for overall long-term success. The certification training through the Institute on Employment and Disability in Cornell University's Industrial and Labor Relations School will prepare

agency staff to support enrolled participants to develop a clear, comprehensive, and actionable report of an individual's financial situation and how to maximize self-sufficiency trends. There is not currently a more viable way to increase skills of agency staff and to increase the numbers of certified benefit planners.

Addressing State Needs and Gaps, Including Gaps in Equity:

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a way out of poverty and prevent entry into the disability system. The Individual Placement Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trials that demonstrated implementing Individual Placement Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive employment as compared to individuals not receiving Individual Placement Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

The Foundational Community Support Program is built upon evidenced based practices of SAMHSA and the Westat Rockville Institute to implement supported employment practices that are effective. The principles of these evidence-based practices (EBP) encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. The struggles of poverty and self-sufficiency negatively impact communities of people of color disproportionately. The implementation of based practices accelerates the positive impact on social determinants of health in urban and rural communities. Services are provided are inclusive of all who need them and targeted to individuals with a wide range of disabilities.

Project #: BGCE-RSS10

Project Title: Intentional Peer Support Training

Proposed Budget: \$150,000

*Additional \$150,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

These funds will be used to train Certified Peer Counselors in Intentional Peer Support. These trainings will be provided either in person or in a virtual format depending on physical distancing requirements. Priority for these training will be Certified Peer Counselors (CPCs) who work on the following teams Peer

Bridgers, Housing and Recovery through Peer Services (HARPS), Forensic Housing and Recovery through Peer Services (HARPS), Projects for Assistance in Transition from Homelessness (PATH), Forensic Projects for Assistance in Transition from Homelessness (PATH), Peer Pathfinders, and Foundational Community Support (FCS) teams. The training will be opened up to additional Certified Peer Counselors (CPCs) when space is available. This funding will also be used to provide travel supports for participants.

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors (CPCs) are effective in increasing recovery outcomes in mental health and Substance Use Disorder. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (EDI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS12

Proposed Budget: \$1,120,000

Project Title: Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disorder (SMI/SED).

Scope:

Proposed funds will add one peer counselor to each of the current Projects for Assistance in Transition from Homelessness (PATH). Project for Assistance in Transition from Homelessness (PATH) programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency will be required to hire and onboard a new peer counselor to expand outreach and engagement services for individuals with a serious mental illness (SMI) and homeless or at risk of homelessness. Projects will work closely with

BHASO's, Managed Care Organization's (MCO's) and Crisis stabilization centers to create a referral flow and coordination of services.

The proposed expansion of adding one additional Projects for Assistance in Transition from Homelessness (PATH) peer counselor to each of the Projects for Assistance in Transition from Homelessness (PATH) teams will allow agencies to expand needed outreach and engagement efforts. The proposed funds will enhance the quality of program delivery and engagement and expand critical crisis resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

The intention of Homeless outreach services is to reach individuals who are not currently engaged in treatment, services and who are potentially unable to navigate the system. The ability to have one additional peer outreach team member will allow these programs to broaden the current outreach and engage services to a primary focus of crises response.

Projects for Assistance in Transition from Homelessness (PATH) teams currently serve individuals experiencing homelessness and mental illness and BIPOC communities. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: BGCE-RSS13

Project Title: Creating a Behavioral Health Housing Action Plan

Proposed Budget: \$15,000

*Additional \$15,000 SABG

Scope:

In 2007, the Mental Health State Transformation Initiative generated a Housing Action Plan. The Housing Action Plan conducted an inventory of affordable housing for people with serious mental illness, set a philosophical approach for Housing First principles and identified action steps to improve affordable housing. This proposal seeks to update the Housing Action Plan to include people with substance use disorders.

Washington is experiencing a significant housing crisis. Individuals with behavioral health conditions experience homelessness at a significant rate. The development of a housing action plan will create a north star for the behavioral health system to pursue partnerships to create and develop affordable housing.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will identify and analyze the needs and gaps for affordable housing for the behavioral health population. It will develop an action plan to meet the affordable housing needs of individuals with both mental health and substance use disorders.

The Behavioral Health Affordable Housing Action plan will analyze the impacts of homelessness on the BIPOC population. According to Research and Data Analysis, individuals experiencing homelessness are more likely to be African American or Alaska Native/American Indians (Ford-Shah, M., 2012)

Project #: BGCE-RSS14

Project Title: Creating a Housing Inventory/Estimator/Calculator

Proposed Budget: \$150,000

*Additional \$150,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Prison and jail re-entry and enhanced discharge from inpatient settings in order to reduce risks of COVID-19 transmission.

Scope:

The Research and Data Analysis Division (RDA) within the Department of Social and Health Services (DSHS) completed a series of reports in 2012 examining the housing status of individuals following their exit from institutional or out-of-home care settings. More than one-quarter of all five study populations (individuals leaving Substance Use Treatment Facilities; State Department of Corrections Facilities; Foster Care; State Mental Hospitals and Juvenile Rehabilitation Facilities) experienced homelessness at some point over a 12-month follow-up period. This project will create an online searchable tool based on various scenarios to connect individuals with behavioral health conditions to housing. Based on a current algorithm currently housed in the Pathways to Employment Site, Research and Data Analysis will create a housing version for the Pathways to Housing site.

This searchable tool that will be housed on the Research and Data Analysis Pathways to Housing site will be used to help address the fact that almost 50 percent of Individuals leaving residential substance use treatment facilities became homeless within the year of discharge. Individuals exiting prison, foster care, State Mental Hospitals, and Juvenile Rehabilitation facilities were more likely to experience homelessness but as likely to obtain to permanent housing when they received housing assistance. Across the five study populations, the proportion of individuals in need of housing who received Homeless Management Information System (HIMS)-recorded assistance was highest for youth aging out of foster care (at 35 percent). Even though this report is dated, it is believed these relate to the population we intend to start with: individuals with behavioral health issues still exist and may even be more exacerbated with the COVID pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will provide timely information for individuals with behavioral health conditions to access housing services and resources.

The searchable housing tool will ensure individuals with Behavioral Health conditions and part of the BIPOC population will have access to housing services and resources.

Project #: BGCE-RSS15

Project Title: Peer Dashboard

Proposed Budget: \$100,000

*Additional \$100,000 SABG

Scope:

This funding would be used to create a Dashboard for the Peer Support Program. This would enable the team to see data pulled from the Peer Support database on an easily accessible format. There is increased focus on the peer support program to meet the growing workforce needs. This dashboard would allow the Health Care Authority to have immediate access to data for updates to lawmakers and stakeholders. Without the dashboard the Peer Support Team and leadership would not have easily accessible data about the Peer Support Program.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is a Behavioral Health workforce shortage in Washington and peer services are a growing workforce that can help to meet the Behavioral Health needs of our communities. The dashboard will allow the Division of Behavioral Health and Recovery easy access to data that could direct the Peer Support Program where to focus trainings where gaps are identified to increase the Certified Peer Counselor (CPC) workforce and the diversity of the Certified Peer Counselor workforce.

Programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS17

Proposed Budget: \$15,000

*Additional \$15,000 SABG

Project Title: White Paper/Toolkits/Medicaid Academy for Peer-Run Peer-Operated Agencies

Scope:

This funding would be used to create a white paper to explore strategies for peer run/peer operated agencies to become licensed community behavioral health agencies so that they will be able to bill Medicaid for peer services.

This would provide technical assistance for clubhouse and consumer run organizations to become licensed providers and bill Medicaid for peer services. This will increase recovery support services to a larger portion of the state. Washington State supports several clubhouse programs using general fund

dollars and SB 5328 is proposing that the state go farther in helping clubhouses gain access to Medicaid funds. This project aligns with the bill to assist those organizations to bill Medicaid.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently a shortage of behavioral health workers across Washington State. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. This would allow additional agencies to become licensed to provide peer services increasing the availability of Mental Health and Substance Use Disorder (SUD) peer services to a larger population. If unfunded, this technical assistance will not be available in the state and could delay agencies in getting licensed to provided peer services.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS18

Proposed Budget: \$50,000
*Additional \$50,000 SABG

Project Title: Foundational Community Support (FCS) – Converting Current Training to Online Training Modules

Scope:

Foundational Community Supports (FCS) provides supported employment and supportive housing services across the state of Washington with over 160 agencies contracted to provide Foundational Community Support (FCS) services. The Division of Behavioral Health and Recovery (DBHR) has four full time trainers who provide technical assistance to Foundational Community Support (FCS) providers. The growth of Foundational Community Support (FCS) has increased the need for technical assistance/training and the Division of Behavioral Health and Recovery (DBHR) would like to convert some of the "stock" training that it provides to all new Foundational Community Support (FCS) providers to a virtual format. Creating online training modules of stock trainings currently provided in person will free up time for Foundational Community Support (FCS) trainers to provide more individualized, targeted, and intense technical assistance.

This project is critical to maintaining and improving the quality of services provided by Foundational Community Support (FCS) providers. Focused, targeted, and high-level training ensures consistency and

adherence to the evidence-based modules that Foundational Community Support uses. Currently, the Division of Behavioral Health and Recovery Foundational Community Support trainers are spending much of their time delivering stock training to providers as they onboard new staff. This type of training could easily be provided in a virtual recorded format that would free up the Foundational Community Support (FCS) trainers time to provide more advanced targeted technical assistance to providers. Freeing up the Foundational Community Support (FCS) trainers time to focus on more targeted and nuanced technical assistance allows us to grow the quality of the Foundational Community Support program.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal justice interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a way out of poverty and prevent entry into the disability system. The Individual Placement Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trails that demonstrated implementing Individual Placement Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive employment as compared to individuals not receiving Individual Placement Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

Foundational Community Supports utilizes the evidence-based practices of SAMSHA's Permanent Supportive Housing and Westat's individual placement and support. The principles of these evidence-based practices encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. These services also value and approach participants with equity, respect as well as cultural humility with the hope of promising outcomes.

Project #: BGCE-RSS19

Proposed Budget: \$500,000

*Additional \$500,000 SABG

Project Title: Cover Foundational Community Support (FCS) Services in Institution of Mental Disease (IMD) When Medicaid is Suspended

Scope:

The Division of Behavioral Health and Recovery proposes to utilize block grant funds to cover Foundational Community Support services for people transitioning out of Institution of Mental Disease (IMD) settings if the Medicaid isn't retroactively reconnected. The Foundational Community Support (FCS) program assists eligible individuals with complex health needs obtain and maintain stable housing and can provide Foundational Community Support services within short-term Institution of Mental Disease (IMD) settings with housing assessments and begin the housing acquisition process prior to discharge. These newly added services to Foundational Community Support will include coaching, advocacy, information and referral, linking and coordinating, and ongoing supports that they may not otherwise have access to.

The program offers an array of transition/pre-tenancy and tenancy-sustaining supports that have been effective in improving housing stability, health and employment outcomes for high need Medicaid beneficiaries. linking and coordinating, and ongoing supports that they may not otherwise have access to. Many of these individuals have complex health profiles and face multiple housing related barriers to effectively engaging with health care systems and managing their own plan of care to achieve improved health and wellness. Foundational Community Support have reduced the frequent use of emergency department and inpatient care, addressed significant gaps in connections to care, addressed homelessness, and now can help to facilitate timely, successful transitions from institutional settings to integration in community placements. Anticipated Outcomes:

- Effectively target interventions to eligible individuals in residential treatment settings;
- Streamline and standardize transition and tenancy-sustaining services for individuals exiting residential treatment across agencies and systems;
- optimize and braid all available funding to fill gaps;
- reduce Substance Use Disorder/Opioid Use Disorder (SUD/OD) related deaths;
- improve Substance Use Disorder system capacity; and
- improve quality of care

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is no other mechanism to reimburse Foundational Community Support providers if the individuals Medicaid is not active at the time of authorization. The Health Care Authority has taken steps to attempt to mitigate this by providing Foundational Community Support providers access to Provider One to check Medicaid eligibility. This however is not a perfect solution and there are times when Foundational Community Support providers go unpaid.

The Foundational Community Support program is based on the evidence-based practices (EBP) of Permanent Supportive Housing (PSH) and Individual Placement and Support (IPS). The principles of these Evidence-Based Practices encompass equity and racial justice through the promotion of choice, flexible voluntary services, and access.

Project #: BGCE-RSS20

Project Title: Peer Wellness Coach Training

Proposed Budget: \$15,000

*Additional \$15,000 SABG

Scope:

These funds would be used to bring either [REDACTED] Wellness coaching or [REDACTED] Person Medicine Coach certification training to Certified Peer Counselors. [REDACTED] program can also bring a train the trainer to Washington so that we can training Certified Peer Counselors in Personal Medicine Coach training.

This project will provide continuing education to certified peer counselors in Washington State around. The intended outcome is to increase the knowledge of certified peer counselors to even more effectively support the peers they serve. Both programs focus on increased health outcomes. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors.

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors are effective in increasing recovery outcomes in mental health and Substance Use Disorder (SUD). Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors. This continued education will provide information to better support people in whole health as we are moving to a more integrated approach to who person care.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices, and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS22

Project Title: Training for Oxford Outreach Staff

Proposed Budget: \$20,000

*Additional \$20,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

DBHR currently funds 10 outreach staff that provide support to the 300+ Oxford houses in Washington State. Individuals with co-occurring SMI and SUD diagnosis are recipients of the mutual support received within an Oxford house. This proposal is to fund training for the 10 outreach staff to better support the individuals with co-occurring serious mental illness and substance use disorders. Training topics include but not limited to de-escalation, mediation, grief counseling etc.

We would like to add funding for training Oxford House Outreach Workers. There have been too many deaths in the Oxford Houses since COVID-19 started due to isolation and the feelings of hopelessness which brings an increase in drug and fentanyl use and ultimately relapses and deaths. Therefore, there is a need for the 10 Oxford House Outreach Representatives to get trainings on de-escalation, grief and loss, relapse prevention, meditation, Dialectical Behavioral Therapy (DBT), and any other training that would benefit the Oxford House Representatives in helping the residents deal with their grief, losses and fears of relapse.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Oxford House Sober Recovery Homes fills a gap in the substance use disorder services continuum by establishing and maintaining self-run, self-supported peer-operated sober recovery homes. In adherence with United States Code, Title 42, Section §300X–25 Group Homes for Recovering Substance Abusers, the State Agency will utilize the Oxford House concept to increase sober recovery housing assistance opportunities for recovering individuals living together in a residential disciplined environment to maintain recovery without recurrence of use. This level of care includes the provision of a safe and affordable home, in a drug-free living situation to recovering individuals with the support of other peers in recovery, Contractor staff, and other supports and services in the community including mental health guidance from outreach representatives who are trained.

Adult men and women completing residential treatment or are currently in outpatient treatment for substance use disorder, as well as those enrolled in recovery support, and opioid treatment services, who need a place to live and can meet the requirements for being a resident of a Recovery House. People leaving prisons and jails, Oxford House has a strong re-entry program with Department of Corrections (DOC) and does not discriminate on anyone's culture, race, or mores. Recovery housing will also include populations with a reported history of opioid use disorder (OUD) and opioid use.

Project #: BGCE-RSS23

Project Title: Participant Engagement Kits for Youth – Mockingbird

Proposed Budget: \$35,000

*Additional \$35,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice

example. This project would provide funds directly related to benefit participants in homeless outreach teams to assist individuals who are seriously mentally ill and not engaged in treatment. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

The Mockingbird Society creates, supports, and advocates for racially equitable, healthy environments that develop young people at risk of or experiencing foster care or homelessness. The Youth Advocates Ending Homelessness in Washington state report an alarming number of youth experience mental health, substance use disorders and health crisis. This includes advocates that report individuals who are experiencing medical issues that may or may not receive medical treatment. The inability to care for wounds will likely cause more server health issues or worse. Proposing funding for Mockingbird Outreach for Homeless Hygiene and wound care kits such as hand sanitizer, antiseptic, rubbing alcohol, hydrogen peroxide, ointment, band aids, gauze, and pain relievers could make the difference.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Mockingbird Society of Washington report Homeless youth lack access to medical care and often go without essential hygiene and wound care items which are not covered by Medicaid.

The Mockingbird Society creates, supports, and advocates for racially equitable, healthy environments that develop young people at risk of or experiencing foster care or homelessness.

Project #: BGCE-RSS24

Project Title: Peer Pathfinders Transition from Incarceration Pilot

Proposed Budget: \$790,000

*Additional \$790,000 SABG

Scope:

This funding will add a Certified Peer Counselor to up to five existing BH-ASO contracts for jail transition services. Adding a Certified Peer Counselor to existing jail transition services teams will increase the level of services being provided, by having a CPC connect with the individuals while they are still in jail and helping them with transition to the community. The certified peer counselor will work with individuals diagnosed with a serious mental illness, linking them to behavioral health services, including co-occurring treatment, Foundational Community Support (FCS), and other applicable services.

Multiple studies support the fact that Peer support services has significant impacts on quality of life, reducing substance use, and improving positive social supports. Studies have also identified common elements of peer support, suggesting possible processes that underlie effective peer support. Peer services include shared experiences, role modelling, and positive social support. All of which are suggested to be vital aspect of peer support and moderate positive life changes. By adding a certified peer counselor to existing Jail Transition services allows for access to these vital services for individuals with SMI and co-occurring health conditions, reducing likelihood for further court involvement. Impacts that are likely to occur if this project is not approved included recidivism because the individual was not provided the needed services during their jail transition.

Addressing State Needs and Gaps, Including Gaps in Equity:

People exiting jails are more likely to be successful when they are able to connect and engage in services in their communities upon release. Currently in some parts of the state jail transition services are only reaching jail populations a few times a month. By adding a Certified Peer Counselor to existing jail

transition services, individuals who are in need of extra support in accessing community-based services can be offered the support of a peer. These certified peer counselors would focus on linking individuals to behavioral health services, including co-occurring treatment, housing and employment, and community resources.

A disproportionate number of individuals of color are represented in our criminal court system and they experience greater barriers in accessing healthcare and community behavioral healthcare. This problem is greater amplified the further away you move from urban settings and locations in which more services are available. By adding the support of a Certified Peer Counselor to existing jail transition services, this will increase the likelihood of individuals being able to overcome some of these barriers.

Project #: BGCE-RSS25

Project Title: Add Co-Occurring Peer to F-HARPS

Proposed Budget: \$400,000

*Additional \$400,000 SABG

Scope:

These additional funds would allow the teams to hire another certified peer counselor for each Forensic HARPS team in the phase 1 regions. With this additional staff person, the teams would be able to increase caseload capacity. This position would also allow the Forensic HARPS teams to serve individuals diagnosed with serious mental illness or co-occurring.

This project is critical because it will increase the capacity of the teams to serve more eligible individuals through the Forensic HARPS program, an element of the Trueblood Settlement. Housing access, support, and short-term subsidies increase an individual's opportunity for recovery. Housing is a basic need that reduces the likelihood of recidivism in the criminal court system. If this funding is not approved, the Forensic HARPS teams will not be able to serve all those who are eligible and in need of this service.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Forensic HARPS teams have short-term housing subsidy dollars to assist participants in obtaining and maintaining housing. The amount of subsidy dollars allocated to each team is greater than what the current staffing model allows them to spend. With this additional staff person, the Forensic HARPS teams will be able to fully utilize the subsidy dollars allocated to them. Funding Forensic HARPS teams is cost effective because it diverts individuals with serious behavioral health conditions into receiving the services, they need instead of being arrested or hospitalized. Supportive housing reduces inpatient hospitalization, incarceration and engagement in outpatient treatment increases when individuals are successfully housed (RDA, FCS preliminary outcomes 2020).

Helping individuals obtain and maintain housing of their choice helps them be more successful in treatment. Forensic HARPS teams are trained in leveraging all community resources once an individual exits jail or an institutional setting, but the 'bridge subsidy' is still needed in order to assist individuals exit jail as quickly as possible.

A disproportionate number of individuals of color are represented in our criminal court system. Many of these individuals experience significant barriers in accessing safe and affordable housing. WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain

housing, increasing the number of unhoused individuals. People with trauma, a history of homelessness, and co-occurring disorders have an increased likelihood of being involved in the criminal court system. Helping individuals find and maintain housing of their choice, and obtain wanted services, especially during an increased time of hardship such as COVID-19 is our states responsibility.

Project #: BGCE-RSS32

Project Title: Operationalizing Peer Bridger

Proposed Budget: \$25,000

*Additional \$25,000 SABG

Scope:

This funding will be used to create an Operationalizing Peer Support training for the peer Bridger program for jails, hospitals and Substance Use Disorder (SUD) treatment agencies. Operationalizing Peer Support trainings provide Technical Assistance (TA) to existing and new agencies who need support with their peer program or who want to implement peer services. This training would also be to provide technical assistance to the jails, hospitals and inpatient setting who will be collaborating with the peer Bridger program.

As we transition the peer Bridger from providing services at the state hospitals into community-based hospitals and inpatient settings, technical assistance will be beneficial in the transition for the agencies, hospitals, and the peer Bridger program. If not approved, there will be confusion about the peer Bridger program and how to effectively utilize the services resulting in people not receiving these recovery support services. This could increase recidivism into an inpatient setting.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently a shortage of behavioral health workers across Washington State. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. We are currently witnessing gaps in service since the 90/180-day beds went live last year. This needed TA would be able to provide the necessary support and education to effectively utilize the peer Bridger program increasing recovery supports in inpatient settings.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS33

Proposed Budget: \$100,000

Project Title: Create a Dashboard on Healthcare for Workers with Disabilities

Scope:

Washington's Healthcare for Workers with Disabilities is the Medicaid Buy-in Program. Nothing provides 'hope' more than believing that people can work but addressing an individual's concerns about how working affects their governmental benefits is key to implementing the evidence-based practice model called Individual Placement and Support. Benefits counseling is one of the core principles of providing this EBP model. Part of benefits counseling is to help individuals access work incentives such as the Medicaid Buy-in Program to ensure working doesn't have adverse effects to their receipt of services or medications. This project would promote this untapped work incentive program/Medicaid Buy-in program through the creation of a marketing campaign and public dashboard on the utilization of the benefit. According to Research and Data Analysis in the 2nd quarter of 2020, only 12 percent of disabled individuals with a serious mental health issue were employed in Washington State. (10,631/88,381). There are currently 1606 individuals in WA on HWD.

The Apple Health for Workers with Disabilities (HWD) program recognizes the employment potential of people with disabilities and represents Washington State's response to the landmark "Ticket to Work" legislation passed by Congress in 1999. Healthcare for Workers with Disabilities (HWD) is an underutilized program within the state of Washington. This is a critical program to provide low-cost healthcare for people with disabilities, enabling people with disabilities to no longer have to choose between taking a job and having health care, and therefore work to their full potential. Marketing needs to include the message that self-sufficiency is attainable. There is a need to communicate measurements of number of individuals using the service as a part of marketing the program. This proposal is to develop a public facing dashboard as a part of marketing. There will be collaboration between the Health Care Authority departments that have Healthcare for Workers with Disabilities (HWD) as part of the service provided, with the communications department, and with Research and Data Analysis in order to come up with an attractive and fully functioning site that provides current and accurate data.

The benefit to the government is shifting individuals off of benefits and having them add to tax revenue. Under Healthcare for Workers with Disabilities, people with disabilities can earn more money and purchase health care coverage for an amount based on a sliding income scale.

Healthcare for Workers with Disabilities benefits include:

- Medicaid benefit package
- Access to long term services and supports, if functional requirements are met
- Greater personal and financial independence
- Members can earn and save more without the risk of losing their healthcare coverage

If not approved, people with disabilities have less encouragement to work and continue to live below the poverty level while remaining on public benefits. It disproportionately negatively impacts ethnic minorities.

Addressing State Needs and Gaps, Including Gaps in Equity:

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see

work as an essential part of recovery, but many avoid seeking work due to fear of losing benefits. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Results from regressions on earnings suggest that Healthcare for Workers with Disabilities (HWD) participants with prior Medicaid coverage earn substantially more than non-participants in the year following enrollment. On average, they earn roughly \$2,000 more than their contemporary peers in the following year and \$2,500 more than a historical comparison group. Healthcare for Workers with Disabilities (HWD) Participants historically rely less on Basic Food benefits.

Healthcare for Workers with Disabilities (HWD) will create and sustain a culture of respect, caring and inclusion through employment. Programs that focus on employment enhance the value and respect garnered by the individual and help them to sustain their culture in the community. It empowers them to become positive role models. Services provided are inclusive of all who need them and targeted to individuals with a range of disabilities that have become successfully employed. Outreach will address the foregoing population.

Project #: BGCE-RSS35

Project Title: Implicit Biased Training for Landlords

Proposed Budget: \$10,000

*Additional \$10,000 SABG

Scope:

This project would create a training series for landlords on Implicit Bias. Implicit bias describes our attitudes towards people or associates stereotypes with them without our conscious knowledge. Implicit Bias trainings are designed to exposed to people to their biases and provide tools to adjust automatic patterns of thinking and ultimate eliminate discriminatory behaviors.

The Division of Behavioral Health and Recovery would work in partnership with the Department of Commerce's Landlord Mitigation Project to provide training to landlords who often rent to individuals with behavioral health conditions. Training would focus on addressing and identifying implicit biases and how this could be unintendedly affecting their decision on who to rent to.

This project is important because Washington State has a serious deficit of safe and affordable housing. This means that rentals are extremely scarce, and landlords could unintendedly discriminate against people of color and people with behavioral health conditions. The anticipated outcome of this project is to help landlords identify and then address their implicit biases.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal court interactions. The research is clear—homelessness, and unstable housing contribute to poor health.

Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

A disproportionate number of individuals of color experience housing instability. Many of these individuals experience significant barriers in accessing safe and affordable housing. WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. People with trauma, a history of homelessness, and co-occurring disorders have an increased likelihood of being involved in the criminal court system. This training will educate landlords on how their implicit bias might limit who they choose to rent to.

Project #: BGCE-RSS36

Proposed Budget: \$500,000

Project Title: Funding for SSI/SSDI, Outreach, Access, and Recovery (SOAR) Leads

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance.

Scope:

SSI/SSDI Outreach Access and Recovery (SOAR) is a proven effective model to increase access to governmental benefits. This project would create a SOAR Lead Position in multiple regions/counties (scalable). SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads hold local steering committee meetings, lead SSI/SSDI, Outreach, Access and Recovery (SOAR) online course training cohorts and conduct half-day SSI/SSDI, Outreach, Access and Recovery (SOAR) online course review sessions. SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads will also be mentoring individuals who complete the SSI/SSDI, Outreach, Access and Recovery (SOAR) online course and reporting on outcomes.

This will provide increased access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a serious mental illness. Access to these benefits will help individuals stabilize their housing and health.

Addressing State Needs and Gaps, Including Gaps in Equity:

Many unhoused individuals qualify for disability benefits but have a difficult time getting through the application process. With an SSI/SSDI, Outreach, Access Recovery (SOAR) Representative assisting with the application process, individuals are approved more often and more quickly. Most landlords require some kind of monthly income, this will help provide that and allow more individuals to obtain housing.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all

programming. Programs will promote Diversity, Equity and Inclusion and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS41

Project Title: Enhance Mobile Crisis Teams with CPCs

Proposed Budget: \$1,909,000

Scope:

HCA will build upon the Transformation Transfer Initiative (TTI) crisis services continuing education curriculum for Certified Peer Counselors by piloting enhancements to mobile crisis teams by adding Certified Peer Counselors to existing teams. Funds will be issued to BH-ASOs to expand Mobile Crisis Response services serving those diagnosed with SMI/SED.

This project will provide enhance mobile crisis services by adding certified peer counselors in Washington State. The intended outcome is to increase the engagement and outreach of MCR teams to include certified peer counselors to even more effectively support the peers they serve in crisis settings.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. Expanding mobile crisis services to include Certified Peer Counselors will better support people as Washington expands peer services in crisis settings.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote DEI and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Tribal Projects Detail

Project #: BGCE-TRB3

Project Title: Funding to Tribes and Urban Indian Health Organizations

Proposed Budget: \$861,000

*Additional \$1,270,794 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Operation of an “access line,” “crisis phone line,” or “warm lines” to address any mental health issues for individuals.
- Training of staff and equipment that supports enhanced mental health crisis response and services.
- Mental Health Awareness training for first responders and others.
- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).
- Prison and jail re-entry and enhanced discharge from inpatient settings in order to reduce risks of COVID-19 transmission.
- COVID-19 related expenses for those with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED), including testing and administering COVID vaccines, COVID awareness education, and purchase of Personal Protective Equipment (PPE)

Scope:

The Health Care Authority will provide contracts to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver needed mental health services to adults and youth with SMI/SED to prevent, prepare for and respond to behavioral health gaps due to COVID within their Tribal communities. Tribes would submit a plan to implement recommended services as outlined in the NOA and allowed within the Mental Health Block Grant (MHBG) regulations. Additional Funds to Tribes \$40,993 SABG per Tribe and \$27,778 MHBG per Tribe, totaling \$68,771 for each Tribe.

This project is important because American Indian/Alaskan Native (AI/AN) and Tribal communities have been greatly affected by the COVID pandemic and the various Tribal and State Stay at Home Orders. Tribes are navigating how to operate Behavioral Health program in a virtual and semi/virtual environment. Due to the pandemic, Tribes are stating that the individuals in their communities are struggling with social isolation and a lack of treatment services due to the pandemic. There has also been limited cultural activities available for Tribal communities due to the pandemic. The historic annual Canoe Journey was canceled two years in a row with very limited ability to implement cultural programs across all Tribal communities.

Addressing State Needs and Gaps, Including Gaps in Equity:

Department of Health (DOH) reported that overdose rates have gone up over 154% during the first 6 months of the pandemic and is the highest of other communities by race/ethnicity. The statewide increase overall is 30%. The Health Care Authority needs to continue to provide resources to Tribal communities to address those diagnosed with SMI or SED for American Indian/Alaskan Native (AI/AN) in WA. Providing direct funding to Tribes and Urban Indian Health Programs (UIHPs) also honors our government-to-government relationships by partnering with Tribes to serve American Indian/Alaskan Native WA State residents.

This project directly supports Diversity, Equity and Inclusion (DEI) by providing needed services to the American Indian/Alaskan Native (AI/AN) population in providing culturally appropriate services. This also honors our unique Government-to-Government (G2G) relationships with Tribal governments and our partnership with Urban Indian Health Programs (UIHPs).

Crisis Services:

Tribes and Urban Indian Health Programs (UIHPs) may provide crisis services with these funds. The Health Care Authority will pass down National Guidelines to Tribes to provide guidance on best practices for crisis services.

Project #: BGCE-TRB4

Project Title: Traditional Healing Pilot Project

Proposed Budget: \$100,000

*Additional \$100,000 SABG

Scope:

The Health Care Authority will contract with the Seattle Indian Health Board (SIHB) to (1) document best practices (including practice and administrative tools) for an Indian Health Care Provider (IHCP) to offer traditional healing/traditional Indian medicine (TIM) services, and (2) analyze the health outcomes and potential cost savings from offering Traditional Indian Medicine (TIM) services. TIM can serve individuals with SMI/SED and substances use disorder, alongside Western based strategies for the prevention, treatment, and recovery of SMI/SED/SUD. TIM can also help with SMI/SED/SUD prevention. The services may include storytelling, talking circles, drumming, sweat lodge, prayers, blessings (such as cleansing and smudging), etc. TIM services are provided by a community-verified practitioner of TIM. Please note that this grant will not pay for actual TIM services. The Seattle Indian Health Board (SIHB) deliver the following to the Health Care Authority:

1. Recommendations for billing, coding and reimbursement models for Traditional Indian Medicine (TIM) services.
2. Analysis, recommendations, and examples of charting for Traditional Indian Medicine (TIM) services and incorporation of charting into an Electronic Health Record (EHR).
3. Recommendations and analysis on best practices for incorporating Traditional Indian Medicine (TIM) practitioners into integrated care teams.
4. Recommendation and analysis for privileging and credentialing standards of Traditional Indian Medicine (TIM) practitioners and apprentices.
5. Evaluation and analysis of the health outcomes for individuals and populations receiving the Traditional Indian Medicine (TIM) services. Measures could include:
 - Number of services completed;
 - Impacts on health outcomes;
 - Policy analysis;
 - Estimated costs of encounters;
 - Cost benefit analysis;
 - Comparison of the population that receives Traditional Indian Medicine (TIM) and the population that does not;
 - Comparison of patient's perception of their health pre-Traditional Indian Medicine (TIM) services and post-Traditional Indian Medicine (TIM) services, etc.

These items will be submitted as separate reports and guidance documents that will be available for the Health Care Authority, federal partners and other Indian Health Care Providers and Tribes in providing technical assistance on integrating Traditional Indian Medicine (TIM) into health programs with a focus on the treatment and recovery of Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

The Washington Indian Health Care Improvement Act, passed by the state legislature in 2019, had three main goals:

1. Provide resources to ensure the highest possible health status of American Indians/Alaska Natives (AI/AN) in Washington;
2. Raise the health status of American Indian/Alaskan Native (AI/AN); and
3. Ensure tribal self-determination in the areas of health care services.

One recommendation coming out of the Act was the expansion of traditional Indian medicine (TIM). This project helps the Health Care Authority to honor this key recommendation. Traditional Indian Medicine (TIM) services provide unparalleled support for American Indian/Alaskan Natives individuals struggling with severe mental illness or severe emotional disturbances and Western medicine has proven to not be appropriate for treatment and recovery supports for these American Indian/Alaskan Native (AI/AN) individuals. The anticipated outcome is documentation of positive health outcomes for individuals receiving Traditional Indian Medicine (TIM) and guidance to other Indian Health Care Providers (IHCP) on how to incorporate Traditional Indian Medicine (TIM). If not approved, we will continue to have a lack of literature available to demonstrate positive health outcomes or cost saving of these services for American Indian/Alaskan Native (AI/AN) and therefore, continue to struggle in finding sustainable funding.

Addressing State Needs and Gaps, Including Gaps in Equity:

The WA State Department of Health has found that American Indian/Alaska Native (AI/AN) overdose fatality rates have gone up 154% during the COVID pandemic. There is a known gap in the provision of culturally appropriate services for American Indian/Alaskan Natives (AI/AN) in the state of Washington and at a national level. Tribes and Indian Health Care Providers (IHCPs) are the experts in providing culturally appropriate services; however, Traditional Indian Medicine (TIM) does not have a sustainable funding mechanism. There are many evidence-based practices (EBP) available for Mental Health services; however, there are limited studies with American Indian/Alaskan Natives (AI/AN). Tribes and Indian Health Care Providers (IHCPs) find that implementing Evidence-Based Programs do not always work for American Indian/Alaskan Native (AI/AN) individuals and Tribal communities. This project will seek to develop evidence related to the efficacy of Traditional Indian Medicine (TIM) services for American Indian/Alaskan Natives (AI/AN) suffering from severe emotional disturbance or severe mental illness.

This project directly addresses Diversity, Equity and Inclusion (DEI) principles by providing support for Traditional Indian Medicine (TIM) and integration with clinically based health care. For decades, the response to Traditional Indian Medicine (TIM) is there is a lack of clinical data associating Traditional Indian Medicine (TIM) with better health outcomes. This pilot project will provide guidance around integration of Traditional Indian Medicine (TIM) and clinically based primary care and preliminary data to build the case for Traditional Indian Medicine (TIM). The intent is to provide foundational research and evidence that will support a request for sustainable Medicaid reimbursement for Traditional Indian Medicine (TIM).

Crisis Set-Aside Projects Detail

Project #: BGCE-ASO2

Proposed Budget: \$1,346,000

Project Title: Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding for Crisis Services

Scope:

Funding directed to the Behavioral Health Administrative Service Organizations (BH-ASO's) will support their respective provider networks enhancing the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. Funding will be used to enhance existing Crisis Services provided 24 hours a day, seven days a week including crisis call line, evaluation and treatment services for Individual's ineligible for Medicaid, including involuntary inpatient services, voluntary inpatient services, crisis stabilization services, Employment and Training (E&T) services, and services for the priority populations defined per Contract. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retention issues that have increased throughout the behavioral health delivery system during the pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that

policies and procedures have had different negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation. Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based mental health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health and substance use crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments; and strategies to reduce the fragmentation of mental health care.

Washington

COVID-19 Supplemental Funding Plan for FY21

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

Center for Mental Health Services
Division of State and Community Systems Development

Mental Health Block Grant COVID Supplemental Funding Plan

WA State Summary

The COVID-19 pandemic has had a significant impact on people with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) in Washington State. During the first half of 2019, 8.2% of adults over 18 years of age had symptoms of anxiety disorder and 6.6% had symptoms of depressive disorder. By comparison, in the most recent Household Pulse Survey from the Centers for Disease Control examining trends from February 17, 2021 to March 1, 2021, this prevalence quadrupled to 33.4% for anxiety and 27.7% for depression (in Washington state, rates were slightly higher with 34.2% for anxiety, 14th highest of the 50 states, and 27.8% for depression, 23rd highest of the 50 states). The age group with the highest prevalence rates nationally is 18–29-year-olds (47.2% reporting anxiety, and 42.2% reporting depression). The devastating impacts of the COVID-19 pandemic have clearly impacted young adults' mental health and substance use (a population already at high risk).

As the state and nation emerge from early Phases of the pandemic, the resulting impacts of the last year are a salient concern. People face potentially new obstacles such as continued mental health issues, overcoming the potential disruptions in school, work, and finances, and re-engaging in social life with continued recommendations from the CDC and local health departments (e.g., mask mandates). This is a critical time to address potential harms and to encourage engagement in both adaptive coping behaviors and unique strategies of social engagement within current public health guidelines to reduce high-risk substance use and worsening mental health symptoms, in both adults and youth.

HCA's Division of Behavioral Health and Recovery has reviewed the *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* and allocated a percentage of the total potential COVID-19 relief supplemental funding to address principles focused on recovery needs, support for the behavioral health workforce, particularly of Peers and Recovery Support Peers, and trauma-informed treatment services. The budget summary, on the following pages, provides the detailed amounts allocated across the continuum of behavioral health services through a wide variety of projects, treatment funds provided through our Behavioral Health Administrative Service Organizations (BH-ASO's) and Tribes. WA Health Care Authority, with input from partners, including the Behavioral Health Advisory Council, respectfully submits the proposals you will find in the pages to follow.

As part of our effort to seek stakeholder input, the Behavioral Health Advisory Council co-hosted a meeting with the Health Care Authority to invite input from various partners and representatives from across the state's behavioral health system (from Peers to school districts, as well as counties, managed care organizations and others). Input on the proposals was received at the end of the event, which helped to inform the direction, as well as solidify the allocations to each section and confirm what flexibilities to seek within the application for these COVID-19 relief supplemental funds. In addition to waiver flexibilities, the Health Care Authority may also require some flexibility to move allocations from one proposal, to another, within those in this application, in the event a particular proposal is particularly successful and requires funding allocation from another proposal which may not require the entire allocation presented in this application.

Within the budget summary below, you will find the proposed project titles, a brief description and number for each project under the sections of First Episode Psychosis, Treatment, Recovery Support Services and Crisis Services. In the pages that follow, a longer project narrative will include the project title, budgeted amount, a description, or scope of work summary, as well as a narrative of how the project addresses state needs and gaps, especially gaps in equity.

WA is grateful to SAMHSA for the opportunity to apply for the COVID-19 relief supplemental funds, as this has been an unprecedented year of extreme stressors to the most vulnerable among us, and the funding will undoubtedly support those persons at greatest risk, as well as those who seek support in treatment and ongoing recovery.

Project List and Budget Table

FEP Set-Aside			
Project #	Project Title	Project Description	Proposed Budget
Project #: BGCE-CYF7	Rural and AI/AN Pilot Project for FEP	Develop and adapt evidence based coordinated specialty care programs for FEP to meet the needs of rural, frontier and AI/AN communities.	\$ 2,307,000
Total FEP Set-Aside			\$ 2,307,000
Treatment			
Children, Youth and Family Treatment Funding			
Project #	Project Title	Project Description	Proposed Budget
Project #: BGCE-CYF2	Developing Wraparound and Intensive Services (WISe) Workforce Support	Developing Wraparound and Intensive Service (WISe) workforce to support youth with Intellectual Disabilities/Developmental Disabilities (including Autism Spectrum Disorder (ASD)).	\$ 200,000
Project #: BGCE-CYF5	Trauma Focused Cognitive Behavioral Therapy Training	Trauma Focused Cognitive Behavioral Therapy (CBT) Training for clinicians serving children and youth returning to school as part of the triage process post screening.	\$ 376,671
Adult Treatment Funding			

Project #: BGCE- MHA1	Cognitive Behavioral Therapy for Psychosis	Expansion of current contract to deliver Cognitive Behavioral Therapy for Psychosis to a cohort of clinicians who are serving people on 90/180 involuntary civil commitment orders.	\$ 130,000
Project #: BGCE- MHA2	Trauma Informed Care for Designated Crisis Responders	Modify curriculum of Trauma Informed Care training specifically for Designated Crisis Responders to incorporate the skills into their practice.	\$ 50,000
Project #: BGCE- MHA3	Mental Health Specialist Training	Develop a curriculum for a 100-hour course for Mental Health (MH) professionals to secure credentials to become an Older Adult Mental Health Specialist, Intellectual Disabilities /Developmental Disabilities (ID/DD) Mental Health Specialist, and Ethnic Minority Mental Health Specialist.	\$ 396,329
BH-ASO Treatment Funding			
Project #: BGCE- ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding	The community mental health services provided include but are not limited to outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, residents of the service areas who have been discharged from inpatient treatment at a mental health facility, day treatment or other partial hospitalization services, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, or ready for discharge from inpatient psychiatric care, and individuals residing in rural areas.	\$ 6,150,372
Total Treatment			\$ 7,303,372
Recovery Support Services			
Project #	Project Title	Project Description	Proposed Budget

Project #: BGCE- RSS1	Participant Support Funds- Housing and Recovery through Peer Services (HARPS) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	50,000
Project #: BGCE- RSS2	Participant Support Funds- Projects for Assistance in Transition from Homelessness (PATH) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	140,000
Project #: BGCE- RSS3	Participant support Funds - Peer Bridger	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	100,000
Project #: BGCE- RSS7	Certified Peer Counselor (CPC) Online Continuing Education Bank	Create online Certified Peer Counselor (CPC) continuing education trainings.	\$	50,000
Project #: BGCE- RSS8	Foundational Community Support Supported Housing/Supported Employment (SH/SE) 'fidelity reviewer certification'	Creating a Supported Housing (SH) fidelity certification development/Individual Placement and Support (IPS) certification through Westat.	\$	50,000
Project #: BGCE- RSS9	Community Work Incentive Coordinator (CWIC) training and staffing costs for a provider to attend the training	Training for Foundational Community Support service providers to become Community Work Incentive Coordinator (CWIC) trained - https://vcu-ntdc.org/training/introductory/introindex.cfm	\$	50,000
Project #: BGCE- RSS10	Intentional Peer Support Training	Train Certified Peer Counselors in Intentional Peer Support.	\$	150,000
Project #: BGCE- RSS12	Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams	Targeted peer outreach on Project for Assistance in Transition from Homelessness (PATH) teams focusing on a by-name list of individuals who have had multiple contacts with crisis system.	\$	1,120,000

Project #: BGCE-RSS13	Creating a Behavioral Health (BH) Housing Action plan	Inventory of all the housing needs of the Behavioral Health (BH) population.	\$	15,000
Project #: BGCE-RSS14	Creating a housing inventory/estimator/calculator	Provide timely information for individuals with behavioral health conditions to access housing services and resources.	\$	150,000
Project #: BGCE-RSS15	Peer Dashboard	Extract data out of the peer credential data system to have a dashboard.	\$	100,000
Project #: BGCE-RSS17	White paper/Toolkits/Medicaid Academy for Peer Run-Peer Operated Agencies	Creating a white paper on Community Behavioral Health Associate (CBHA) Lite licensing.	\$	15,000
Project #: BGCE-RSS18	Foundational Community Support - Converting Current Training to Online Training Modules	Convert Foundational Community Support training to online training modules.	\$	50,000
Project #: BGCE-RSS19	Cover Foundational Community Support Services in Institution for Mental Disease (IMD) when Medicaid is Suspended	Utilize block grant funds that would cover Foundational Community Support services for people transitioning out of Institution for Mental Disease (IMD) settings if Medicaid does not get retroactively reconnected.	\$	500,000
Project #: BGCE-RSS20	Peer Wellness Coach Training	Peer Wellness Coach continuing education curriculum developed.	\$	15,000
Project #: BGCE-RSS22	Training for Oxford Outreach Staff	De-escalation, mediation, basic grief counseling training for 10 Oxford outreach staff.	\$	20,000
Project #: BGCE-RSS23	Participant Engagement Kits for Youth - Mockingbird	Mental Health Block Grant (MHBG) & Substance Abuse Block Grant (SABG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	35,000

BGCE-RSS24	Peer Pathfinders Transition from Incarceration Pilot	Enhance jail transition programs with SUD peers services to individuals who upon release will be homeless. SUD Peer Services begin prior to release to establish relationship and upon release to support the transition to needed services.	\$ 790,000
BGCE-RSS25	Add Co-Occurring Peer to Forensic-Housing Housing and Recovery through Peer (F-HARPS) Services	Add 1 peer to each of the four Forensic-Housing Housing and Recovery through Peer Services (F-HARPS) in Phase I regions.	\$ 400,000
Project #: BGCE-RSS32	Operationalizing Peer Bridger	Create an operationalizing Peer Bridger program for hospitals, Substance Use Disorder (SUD), and Treatment (TX) agencies.	\$ 25,000
Project #: BGCE-RSS33	Create a Dashboard on Healthcare for Workers with Disabilities (HWD)	Public facing dashboard/Marketing on the number of people using the Medicaid buy-in program.	\$ 100,000
Project #: BGCE-RSS35	Implicit Biased Training for Landlords	Braid funding with Commerce to create a training for landlords.	\$ 10,000
Project #: BGCE-RSS36	Funding for SSI/SSDI Outreach, Access, and Recovery (SOAR) Leads	Helping individuals with the creation of a Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) outreach access and recovery community coordinators.	\$ 500,000
BGCE-RSS41	Enhance Mobile Crisis Teams with CPCs	Pilot enhancements to mobile crisis teams by adding CPCs to existing teams.	\$ 1,909,000
Total Recovery Support Services			\$ 6,344,000
Tribal			
Project #	Project Title	Project Description	Proposed Budget

Project #:	BGCE-TRB3	Grants to Tribes and Urban Indian Health Organizations	Provide grants to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver Substance Use Disorder (SUD) prevention, treatment, Opioid Use Disorder (OUD) intervention and recovery support services within their Tribal communities.	\$	861,000
Project #:	BGCE-TRB4	Traditional Healing Pilot Project	Indian Health Care Provider (IHCP) to offer traditional healing/traditional Indian medicine (TIM) services and analyze the health outcomes and potential cost savings from offering Traditional Indian Medicine (TIM) services.	\$	100,000
Total Tribal				\$	961,119
Crisis Set-Aside					
Project #	Project Title	Project Description		Proposed Budget	
Project #:	BGCE-ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding - Crisis Services	Services include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responders (DCR) services.	\$	1,346,000
Total Crisis Set-Aside				\$	1,346,000
TOTAL SABG Covid Supplement Budget					
FEP Set-Aside				\$	2,307,000
Treatment				\$	7,303,372
Recovery Supports Services				\$	6,344,000
Tribal				\$	961,000
Crisis Set-Aside				\$	1,346,000
Administrative				\$	961,000
Total Budget				\$	19,222,372

First Episode Psychosis Project Detail

Project #: BGCE-CYF7

Project Title: Rural and AI/AN Pilot Project for FEP

Proposed Budget: \$2,307,000

Scope:

Develop and adapt evidence based coordinated specialty care (CSC) programs for first episode psychosis (FEP) to meet the needs of rural, frontier and AI/AN communities. The project would be to help to develop a rural and /or Tribal New Journeys/CSC model, to evaluate it, and broadly disseminate the results to inform future program development. Other states are also interested in figuring out how to develop CSC services in rural areas and Tribal communities. There could be great value in collaborating with partners in other states on this (they would fund their own program development) and could help to define rural and AI/AN CSC in other parts of the U.S.

This work is critical to accomplish the legislative mandate in SSSB 5903 requiring statewide expansion of treatment for FEP. Specialized knowledge and adaptation is essential to meet the unique needs of sparsely populated regions and minority communities in order to achieve the goal of decreasing the duration of untreated psychosis. Considering the magnitude of the impact of schizophrenia, interventions designed to treat the disorder effectively at the earliest possible point (e.g., during the first episode of psychosis) have the potential to improve its long-term trajectory, improve outcomes, improve lives, save lives and save health care dollars and to reduce the health care burden of the illness. The longer a person goes untreated, the more severe and chronic their symptoms become, often resulting in decreased functioning and other negative outcomes over their lifetime.

Addressing State Needs and Gaps, Including Gaps in Equity:

Initial examination of 2018 Medicaid data indicate that extra support is needed to ensure that intervention with first episode is equally available in rural geographical areas and in AI/AN communities. The data suggest there are existing geographical disparities and AI/AN disproportionality. The Washington State Legislature, Children's & Youth Behavioral Health work group (CYBWHG) and SAMSHA have all prioritized early identification and intervention for psychosis. This is so screening and early identification of psychosis among adolescents and young adults will become a universal health care practice, and evidence-based recovery interventions will be available to those who need them.

Treatment Projects Detail

Children, Youth and Family

Project #: BGCE-CYF2

Project Title: Developing WISE Workforce Support

Proposed Budget: \$200,000

Scope:

Developing Workforce & Enhancing Local Care Networks to support Youth with Intellectual or Developmental Disabilities including Autism Spectrum Disorder
Three lead Wraparound and Intensive Services (WISE) behavioral health agencies will plan and implement the project informed by local needs with logistical oversight provided the Wraparound and Intensive Services (WISE) Workforce Collaborative/En Route. A training component will be provided by Seattle Children's Autism Center and offered to a total of five (5) Behavioral Health agencies. The proposed RUBI training model will include:

- (1) An initial 16-hour workshop attended by all WISE team providers;
- (2) 20 weeks of ongoing consultation with the WISE team mental health therapist
- (3) Fidelity review of WISE therapist implementation of RUBI sessions

Agencies selected will have been involved in the Health Care Authority and Developmental Disabilities Administration (DDA) convened Wraparound and Intensive Services (WISE) and Intellectual Disabilities/Developmental Disabilities (ID/DD) and Autism Spectrum Disorder (ASD) workgroup or Project Echo sessions. This allows the project to build more directly on the knowledge and efforts already in process.

The three lead agencies will dedicate a portion of a staff time to participate in developing the specialty team model, attend training, learning collaboratives and consultation. Lead sites will also convene community partners to plan for enhancing their local care network to support youth with Intellectual Disabilities/Developmental Disabilities (ID/DD) and Autism Spectrum Disorder (ASD).

Addressing State Needs and Gaps, Including Gaps in Equity:

During COVID the increased need of trained staff to provide stabilization support for youth in Wraparound and Intensive Services (WISE) with Intellectual Disabilities/Developmental Disabilities (ID/DD) including Autism Spectrum Disorder (ASD) has become apparent. The concern identifying the need for additional training has been expressed by caregivers, behavioral health agency staff and allied system partners. Our behavioral health workforce is often times generalists by education and don't have the training to best support youth with Autism Spectrum Disorder (ASD) and their families. This funding would provide the training support and consultation to five behavioral health agencies as well as enhance community coordination in three regions for youth enrolled in Wraparound and Intensive Services (WISE) with Intellectual Disabilities/Developmental Disabilities including Autism Spectrum Disorder.

The community coordination and development of this project would include outreach to BIPOC communities to participate and provide insight to specific community needs.

Project #: BGCE-CYF5

Project Title: Trauma Focused Cognitive Behavioral Therapy Training **Proposed Budget:** \$376,671

Scope:

Provide training in Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) to clinicians serving children and youth returning to school as part of the triage process post screening as a part of the recommended Department of Health fast response plan to help meet the needs of children and youth returning to school following the Governor's proclamation that in person options are required as of April 1, 2021. This will serve youth who indicate trauma exposure in the screening process (SED). This is following the Sonoma model, and will further enhance the clinical interventions available to children and youth across WA in the long run.

The Governor issued a proclamation that in person options be available across WA as of April 1, 2021. The potentially unmet needs of children and youth over the past year regarding mental health impact are expected to surface as children youth and families begin the transition to in person education. This proposal meets an identified need in the plans to date that matches the requirements of this funding.

Addressing State Needs and Gaps, Including Gaps in Equity:

The workforce serving children youth and families across Washington are dedicated to the age group and the developmentally appropriate interventions needed. This training further supports them in an evidence-based response to the expected wave of trauma exposure from impacts of the pandemic, to support and serve with resilience and strength-based approaches and supports in pushing back compassion fatigue in ensuring they have the tools they need to feel effective in their work, resulting in resilient communities.

Efforts will be made to ensure training is offered to diverse clinician groups including BIPOC and LGBTQ+ clinician groups.

Adult Treatment

Project #: BGCE-MHA1

Project Title: Cognitive Behavioral Therapy for Psychosis **Proposed Budget:** \$130,000

Scope:

This project will expand upon our current contract with the University of Washington's Supporting Psychosis Innovation through Research, Implementation and Training (SPIRIT) Lab to deliver Cognitive Behavioral Therapy for Psychosis to a cohort of outpatient and inpatient clinicians from selected contracted community-based sites who are serving people receiving 90/180 involuntary civil commitment orders. This Evidence Based Practice (EBP) helps people living with psychosis achieve a level of self-management that has shown great success, supporting individuals and their families in the community.

Many of the people on these long-term involuntary commitments experience psychosis so this Evidence Based Practice is a good fit for the needs of this population. We will train two cohorts of clinicians- each cohort containing staff from an inpatient setting serving people on 90/180 involuntary civil commitment orders and a corresponding outpatient behavioral health agency that treats these individuals upon discharge- or may have treated the individual prior to admission. This will allow the skills learned in either setting to be supported and reinforced in the other setting. The plan is to first train the clinicians to a level of competency such that they then can be trained to supervise others with the model. It would then broaden to be delivered in group treatment and then be the model of treatment across the milieu for those in inpatient settings. We believe that this implementation plan should have good sustainability for these sites.

Training outpatient behavioral health agency staff and their locally corresponding contracted long term civil commitment sites in an appropriate Evidence Based Practice should assist this population in better managing their symptoms and reduce their need for further involuntary or inpatient treatment. This recovery-based model supports both the individual and their family which should help individuals to successfully remain in the community.

Addressing State Needs and Gaps, Including Gaps in Equity:

Training our Behavioral Health workforce in Cognitive Behavioral Therapy (CBT) for Psychosis will help empower individuals living with psychosis to better manage symptoms that interfere with their ability to live their lives in the community. The Behavioral Health workforce needs enhanced tools to treat psychosis beyond simply medication alone. This evidence-based practice is targeted to the needs of a population that traditionally does not receive therapy as many clinicians do not know about Cognitive Based Therapy (CBT) for Psychosis and its success rate. Additionally, the facilities that have begun to take individuals on long term orders have reported a need for more enhanced programming for this population and it is important to provide continuity of care, including support for skills development, across care settings.

People living with psychosis experience much social isolation due to their symptoms. By providing them with greater skills to manage psychosis, this inequity will be better addressed. This enhancement will serve all populations living with psychosis, including members of BIPOC communities but is not a targeted outreach to them specifically.

Project #: BGCE-MHA2

Project Title: Trauma Informed Care for Designated Crisis Responders **Proposed Budget:** \$50,000

Scope:

Modify curriculum of Trauma Informed Care Training specifically for Designate Crisis Responders so that Designated Crisis Responders (DCR) can incorporate the skills into their practice. Conducting involuntary treatment investigations can be innately traumatizing. Incorporating trauma informed techniques into the Designative Crisis Responder (DCR) skill set can help make the investigations less traumatizing, and hopefully minimize long term trauma from the involuntary treatment process.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently no trauma informed care training specific to the work Designative Crisis Responders do. Involuntary Treatment Act (ITA) evaluations can be traumatizing for the people performing the evaluation. To minimize the impact to the Designated Crisis Responders, the individuals being evaluated and the system as a whole, this training is immediately necessary.

Individuals in BIPOC communities and those with serious behavioral health issues are more likely to have encounters with law and healthcare systems that result in furthering trauma. The trauma that effects the individual being evaluated also impacts the person doing the evaluation. Proper training can help improve the interactions between Designated Crisis Responders, law enforcement and individuals receiving treatment. This will assist in more sustainable recovery for every individual, and a system prepared to support those in need.

Project #: BGCE-MHA3

Project Title: Mental Health Specialist Training

Proposed Budget: \$396,329

Scope:

Develop curricula for a 100-hour course for Mental Health Professionals who provide treatment services to individuals with SMI or SED to secure credential to become an Older Adult Mental Health Specialist, Intellectual Disabilities/Developmental Disabilities (ID/DD) Mental Health Specialist, and Ethnic Minority Mental Health Specialist as defined in Washington's Rehab State Plan for Mental Health Outpatient (OP) treatment. Training curricula will focus on recognizing unique needs of these populations, clinical best practices, understanding of the community resources and partners when working with these populations, the role of Mental Health Specialist and how to provide clinical consultation, cultural humility, and other relevant information specific to each demographic.

The Division of Behavioral Health and Recovery (DBHR) has not sponsored Mental Health Specialists academies for almost ten years and as such, there are significant workforce shortages in specialists trained and credentialed to work with the older adult population, individuals with intellectual and developmental disabilities, and ethnic minorities. Each of these populations has unique needs or considerations that impact care and the behavioral health workforce needs additional training and supports in order to meet their needs. The overall intent is to provide better care for clinicians who provide services to SMI and SED populations.

Addressing State Needs and Gaps, Including Gaps in Equity:

With a fast-growing aging population, the need for mental health professionals trained and sufficiently skilled to work with older adult population is more critical than ever. The current workforce requires specialized skills and knowledge to better support BIPOC populations and people with Intellectual Disabilities/Developmental Disabilities. This is a work force shortage that must be addressed.

BIPOC communities, older adults, and people with Intellectual Disabilities/Developmental Disabilities must receive culturally appropriate services from clinicians with relevant education, experience, and skills. This is a matter of equity and parity.

BH-ASO Treatment Funding

Project #: BGCE-ASO2

Project Title: Behavioral Health Administrative Services Organization (BH-ASO) Treatment Funding
Proposed Budget: \$6,150,372

Scope:

Funding directed to the Behavioral Health Administrative Services Organizations (BH-ASO) will support their respective provider networks enhancing the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. This includes a regionally based system of care that includes mental health services to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities. Including increasing capacity of Designated Crisis Responder (DCR) and Tribal Designated Crisis Responder (DCR) services.

The community mental health services are provided to individuals with serious mental illness/serious emotional disturbance including specialized outpatient services for American Indian/Alaskan Native (AI/AN), children, and the elderly. Services provided include but are not limited to outpatient services for individuals who have been **discharged** from inpatient treatment, day treatment, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, and individuals residing in rural areas. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retainment issues that have increased throughout the behavioral health delivery system during the pandemic.

If funding were not approved the statewide behavioral health service delivery system will continue to face funding gaps, service delivery delays, and individuals diagnosed with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) will be less likely to have opportunities to access services and function better in their communities experiencing an improved quality of life. Further, an opportunity to enhance and improve ongoing behavioral health system workforce recruitment and staff retention worsened by the pandemic will be missed.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support, and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that policies and procedures have had negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation.

Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based behavioral health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments.

Recovery Support Services Projects Detail

Project #: BGCE-RSS1

Project Title: Participant Support Funds – Housing and Recovery through Peer Services (HARPS) Teams
Proposed Budget: \$50,000

*Additional \$50,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice example. This project would provide funds directly related to benefit participants in the HARPS program to assist individuals who are transitioning from inpatient settings to the community. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

We expect the housing crisis and behavioral health crisis to intensify as eviction protections are lifted. The Housing and Recovery through Peer Support (HARPS) priority population is unable to earn wages while involved with inpatient treatment and is unlikely to have savings to secure housing upon discharge. Additionally, many participate intensive outpatient treatment which limits the amount of time to earn wages to afford housing, as well as other necessities to stay engaged in treatment and recovery activities.

Adding additional support funds to each Housing and Recovery through Peer Services (HARPS) contract to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination of other healthcare services and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Participant Support Funds will help the Housing and Recovery through Peer Support (HARPS) Teams to interweave care coordination, case management, and outreach services. People experiencing homelessness and behavioral health conditions benefit from connections to peer services and resources.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity

through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS2

Project Title: Participant Support Funds – Projects for Assistance in Transition from Homelessness (PATH) Teams
Proposed Budget: \$140,000

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice example. This project would provide funds directly related to benefit participants in the homeless outreach teams to assist individuals who are seriously mentally ill and not engaged in treatment. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

Proposed support service funds will be added to the current contracted programs, Projects for Assistance in Transition from Homelessness (PATH). PATH programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency will be required to develop a detailed plan describing method and intended outcome for allocating client support service funding and submit to the Health Care Authority for approval by 09/30/2021. Plan must be based on Mental Health Block Grant (MHBG) guidance for Target Population* and Statement of Work.

Persistent and consistent outreach and providing services at the individual's pace are important steps to engage people with serious mental illness who are homeless. The proposed support service funds will enhance the quality of program delivery and engagement and expand critical client resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

Homeless outreach services intention is to reach individuals who are not currently engaged in services and potentially unable to navigate the system. The ability to have support services that offer basic needs upon engagement increases the likelihood for engagement in treatment and recovery.

PATH teams serve individuals experiencing homelessness and Serious Mental Illness (SMI) to BIPOC communities. BIPOC communities are overrepresented in homelessness. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: BGCE-RSS3

Project Title: Participant Support Funds – Peer Bridger

Proposed Budget: \$100,000

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).
- COVID-19 related expenses for those with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED), including testing and administering COVID vaccines, COVID awareness education, and purchase of Personal Protective Equipment (PPE).

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice example. This project would provide funds directly related to benefit participants with serious mental illness who are transitioning from inpatient settings to the community. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

The goal of this project is to use participant funds to connect people to community supports and treatment and reduce recidivism to the state hospital admissions. Keeping individuals engaged in peer services creates personal connection, accountability, and someone to assist in navigating complicated systems. Without these added supports the system continues to be a revolving door for many.

MHBG Funds could be used to support case managers, outreach workers, Assertive Community Treatment Services For people experiencing homelessness, medications, coordination with primary care, and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support improves engagement and increases hope by modeling recovery. These complimentary services will enhance the already proven Peer Bridger model.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS7

Project Title: Certified Peer Counselor (CPC) Online Continuing Education Bank

Proposed Budget: \$50,000

*Additional \$50,000 SABG

Scope:

This funding would be used to create online Certified Peer Counselor (CPC) continuing education trainings. The trainings could include Wellness Recovery Action Plans (WRAP), Crisis Plans, Suicide Prevention, cultural awareness, and others. The goal is to great online learning bank for Certified Peer Counselors where they can access continuing education trainings on demand.

These trainings would be accessible for all certified peer counselors in Washington and the knowledge gained will improved peer services provided in Washington. Traditionally Certified Peer Counselors (CPCs) continuing education trainings have been funded by DBHR, during the past year we have had to reallocate funding to meet the needs of the Certified Peer Counselor workforce by increasing our core Certified Peer Counselor (CPC) trainings. These online trainings will be able to be accessed by peers across the state no matter where they reside or work and removing barriers to access. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors (CPCs).

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors (CPCs) are effective in increasing recovery outcomes in mental health and Substance Use Disorder (SUD). Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors. Continuing education for certified peer counselors is always requested and providing these trainings in a virtual format will make the trainings more accessible to peers in all areas of the state.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS8

Project Title: Foundational Community Support (FCS) Supported Housing/Supported Employment (SH/SE) Fidelity Reviewer Certification

Proposed Budget: \$50,000

*Additional \$50,000 SABG

Scope:

Intensive Trainings for Foundational Community Supports (FCS) providers to increase their skills/trainings on SAMSHA Permanent Supportive Housing (PSH) Fidelity Reviews and Individual Placement and Support (IPS) Support Employment Fidelity Reviews.

Washington State Foundational Community Support programs uses two evidence-based models- SAMSHA Permanent Supportive Housing and WESTAT/Rockville Institutes Individual Placement and Support Supported Employment Model. To ensure high quality standards and fidelity to these models, Foundational Community Support (FCS) providers participate in fidelity reviews. This funding will allow Foundational Community Support provider to participate in intensive training to able to provide high quality fidelity reviews and ensure compliance with the evidenced based practices.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal justice interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a way out of poverty and prevent entry into the disability system. The Individual Placement and Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trails that demonstrated implementing Individual Placement and Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive employment as compared to individuals not receiving Individual Placement and Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement and Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

Foundational Community Supports utilizes the evidence-based practices of SAMSHA's Permanent Supportive Housing and Westat's individual placement and support. The principles of these evidence-based practices encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. These services also value and approach participants with equity, respect as well as cultural humility with the hope of promising outcomes.

Project #: BGCE-RSS9

Proposed Budget: \$50,000

Project Title: Community Work Incentive Coordinator (CWIC) Training and Staffing Costs

Scope:

This project proposes to use MHBG funds to cover Staff training costs for community behavioral health agencies to become Community Work Incentive Coordinators. Nothing provides 'hope' more than believing that people can work but addressing an individual's concerns about how working affects their governmental benefits is key to implementing the evidence-based practice model called Individual Placement and Support. Benefits counseling is one of the core principles of providing this EBP model.

Washington State's Foundational Community Supports (FCS) supported employment providers serve individuals using the Evidence Based Practice of Individual Placement and Support, the program developed and managed by Westat Rockville Institute. Washington state legislature mandated the use of evidence based or promising practices when Foundational Community Support (FCS) was approved. The intent is for the service to be statewide and in order to positively impact sustainability, services should be provided to fidelity in order to achieve the greatest outcomes. An important element of the principles of Individual Placement and Support is the education of job seekers of how income may impact federal and state benefits and entitlements. There is currently not the bandwidth in Washington's State to provide work incentive education and planning to enroll individuals in the Foundational Community Support system. The proposal is to send Foundational Community Support (FCS) agency staff from agencies to enroll in webinars to learn the foundational knowledge of Social Security work incentives, and to secure certification training for select agency staff at behavioral health organizations in Western and Eastern Washington State. This initiative will greatly increase the number of benefit practitioners to education and support job seekers in the transition to competitive employment, attain self-sufficiency while decreasing reliance on public entitlement programs. The Institute on Employment and Disability in Cornell University's Industrial and Labor Relations School training also has a credentialing option that provides a pathway to be recognized as an accredited work incentive planner. Work incentives pave the way to work and financial independence for recipients of public benefits. This training will provide essential insight into how the complex mix of work incentives, critically needed benefits, and earnings can be explained to an individual with a disability to encourage both work and financial independence.

There is a critical need for the training of benefit education planners in Washington State. The Foundational Community Support (FCS) program has 162 providers with 458 service location, with an enrollment of over 3,000 individuals. the availability of agency staff with foundational knowledge and access to certified benefit planners is crucial to provide support to enrolled participants and learn how earned income can impact entitlement benefits. These training opportunities will provide staff essential tools to assist job seekers to reach their individual goal of self-sufficiency. The implementation and practices of the Individual Placement Support (IPS) supported employment model are expanding in Washington State, and the critical need to adequately prepare agency staff of benefit planning curriculum is essential for overall long-term success. The certification training through the Institute on Employment and Disability in Cornell University's Industrial and Labor Relations School will prepare

agency staff to support enrolled participants to develop a clear, comprehensive, and actionable report of an individual's financial situation and how to maximize self-sufficiency trends. There is not currently a more viable way to increase skills of agency staff and to increase the numbers of certified benefit planners.

Addressing State Needs and Gaps, Including Gaps in Equity:

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a way out of poverty and prevent entry into the disability system. The Individual Placement Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trials that demonstrated implementing Individual Placement Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive employment as compared to individuals not receiving Individual Placement Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

The Foundational Community Support Program is built upon evidenced based practices of SAMHSA and the Westat Rockville Institute to implement supported employment practices that are effective. The principles of these evidence-based practices (EBP) encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. The struggles of poverty and self-sufficiency negatively impact communities of people of color disproportionately. The implementation of based practices accelerates the positive impact on social determinants of health in urban and rural communities. Services are provided are inclusive of all who need them and targeted to individuals with a wide range of disabilities.

Project #: BGCE-RSS10

Project Title: Intentional Peer Support Training

Proposed Budget: \$150,000

*Additional \$150,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

These funds will be used to train Certified Peer Counselors in Intentional Peer Support. These trainings will be provided either in person or in a virtual format depending on physical distancing requirements. Priority for these training will be Certified Peer Counselors (CPCs) who work on the following teams Peer

Bridgers, Housing and Recovery through Peer Services (HARPS), Forensic Housing and Recovery through Peer Services (HARPS), Projects for Assistance in Transition from Homelessness (PATH), Forensic Projects for Assistance in Transition from Homelessness (PATH), Peer Pathfinders, and Foundational Community Support (FCS) teams. The training will be opened up to additional Certified Peer Counselors (CPCs) when space is available. This funding will also be used to provide travel supports for participants.

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors (CPCs) are effective in increasing recovery outcomes in mental health and Substance Use Disorder. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (EDI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS12

Proposed Budget: \$1,120,000

Project Title: Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disorder (SMI/SED).

Scope:

Proposed funds will add one peer counselor to each of the current Projects for Assistance in Transition from Homelessness (PATH). Project for Assistance in Transition from Homelessness (PATH) programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency will be required to hire and onboard a new peer counselor to expand outreach and engagement services for individuals with a serious mental illness (SMI) and homeless or at risk of homelessness. Projects will work closely with

BHASO's, Managed Care Organization's (MCO's) and Crisis stabilization centers to create a referral flow and coordination of services.

The proposed expansion of adding one additional Projects for Assistance in Transition from Homelessness (PATH) peer counselor to each of the Projects for Assistance in Transition from Homelessness (PATH) teams will allow agencies to expand needed outreach and engagement efforts. The proposed funds will enhance the quality of program delivery and engagement and expand critical crisis resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

The intention of Homeless outreach services is to reach individuals who are not currently engaged in treatment, services and who are potentially unable to navigate the system. The ability to have one additional peer outreach team member will allow these programs to broaden the current outreach and engage services to a primary focus of crises response.

Projects for Assistance in Transition from Homelessness (PATH) teams currently serve individuals experiencing homelessness and mental illness and BIPOC communities. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: BGCE-RSS13

Project Title: Creating a Behavioral Health Housing Action Plan

Proposed Budget: \$15,000

*Additional \$15,000 SABG

Scope:

In 2007, the Mental Health State Transformation Initiative generated a Housing Action Plan. The Housing Action Plan conducted an inventory of affordable housing for people with serious mental illness, set a philosophical approach for Housing First principles and identified action steps to improve affordable housing. This proposal seeks to update the Housing Action Plan to include people with substance use disorders.

Washington is experiencing a significant housing crisis. Individuals with behavioral health conditions experience homelessness at a significant rate. The development of a housing action plan will create a north star for the behavioral health system to pursue partnerships to create and develop affordable housing.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will identify and analyze the needs and gaps for affordable housing for the behavioral health population. It will develop an action plan to meet the affordable housing needs of individuals with both mental health and substance use disorders.

The Behavioral Health Affordable Housing Action plan will analyze the impacts of homelessness on the BIPOC population. According to Research and Data Analysis, individuals experiencing homelessness are more likely to be African American or Alaska Native/American Indians (Ford-Shah, M., 2012)

Project #: BGCE-RSS14

Project Title: Creating a Housing Inventory/Estimator/Calculator

Proposed Budget: \$150,000

*Additional \$150,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Prison and jail re-entry and enhanced discharge from inpatient settings in order to reduce risks of COVID-19 transmission.

Scope:

The Research and Data Analysis Division (RDA) within the Department of Social and Health Services (DSHS) completed a series of reports in 2012 examining the housing status of individuals following their exit from institutional or out-of-home care settings. More than one-quarter of all five study populations (individuals leaving Substance Use Treatment Facilities; State Department of Corrections Facilities; Foster Care; State Mental Hospitals and Juvenile Rehabilitation Facilities) experienced homelessness at some point over a 12-month follow-up period. This project will create an online searchable tool based on various scenarios to connect individuals with behavioral health conditions to housing. Based on a current algorithm currently housed in the Pathways to Employment Site, Research and Data Analysis will create a housing version for the Pathways to Housing site.

This searchable tool that will be housed on the Research and Data Analysis Pathways to Housing site will be used to help address the fact that almost 50 percent of Individuals leaving residential substance use treatment facilities became homeless within the year of discharge. Individuals exiting prison, foster care, State Mental Hospitals, and Juvenile Rehabilitation facilities were more likely to experience homelessness but as likely to obtain to permanent housing when they received housing assistance. Across the five study populations, the proportion of individuals in need of housing who received Homeless Management Information System (HIMS)-recorded assistance was highest for youth aging out of foster care (at 35 percent). Even though this report is dated, it is believed these relate to the population we intend to start with: individuals with behavioral health issues still exist and may even be more exacerbated with the COVID pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will provide timely information for individuals with behavioral health conditions to access housing services and resources.

The searchable housing tool will ensure individuals with Behavioral Health conditions and part of the BIPOC population will have access to housing services and resources.

Project #: BGCE-RSS15

Project Title: Peer Dashboard

Proposed Budget: \$100,000

*Additional \$100,000 SABG

Scope:

This funding would be used to create a Dashboard for the Peer Support Program. This would enable the team to see data pulled from the Peer Support database on an easily accessible format. There is increased focus on the peer support program to meet the growing workforce needs. This dashboard would allow the Health Care Authority to have immediate access to data for updates to lawmakers and stakeholders. Without the dashboard the Peer Support Team and leadership would not have easily accessible data about the Peer Support Program.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is a Behavioral Health workforce shortage in Washington and peer services are a growing workforce that can help to meet the Behavioral Health needs of our communities. The dashboard will allow the Division of Behavioral Health and Recovery easy access to data that could direct the Peer Support Program where to focus trainings where gaps are identified to increase the Certified Peer Counselor (CPC) workforce and the diversity of the Certified Peer Counselor workforce.

Programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS17

Proposed Budget: \$15,000

*Additional \$15,000 SABG

Project Title: White Paper/Toolkits/Medicaid Academy for Peer-Run Peer-Operated Agencies

Scope:

This funding would be used to create a white paper to explore strategies for peer run/peer operated agencies to become licensed community behavioral health agencies so that they will be able to bill Medicaid for peer services.

This would provide technical assistance for clubhouse and consumer run organizations to become licensed providers and bill Medicaid for peer services. This will increase recovery support services to a larger portion of the state. Washington State supports several clubhouse programs using general fund

dollars and SB 5328 is proposing that the state go farther in helping clubhouses gain access to Medicaid funds. This project aligns with the bill to assist those organizations to bill Medicaid.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently a shortage of behavioral health workers across Washington State. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. This would allow additional agencies to become licensed to provide peer services increasing the availability of Mental Health and Substance Use Disorder (SUD) peer services to a larger population. If unfunded, this technical assistance will not be available in the state and could delay agencies in getting licensed to provided peer services.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS18

Proposed Budget: \$50,000
*Additional \$50,000 SABG

Project Title: Foundational Community Support (FCS) – Converting Current Training to Online Training Modules

Scope:

Foundational Community Supports (FCS) provides supported employment and supportive housing services across the state of Washington with over 160 agencies contracted to provide Foundational Community Support (FCS) services. The Division of Behavioral Health and Recovery (DBHR) has four full time trainers who provide technical assistance to Foundational Community Support (FCS) providers. The growth of Foundational Community Support (FCS) has increased the need for technical assistance/training and the Division of Behavioral Health and Recovery (DBHR) would like to convert some of the "stock" training that it provides to all new Foundational Community Support (FCS) providers to a virtual format. Creating online training modules of stock trainings currently provided in person will free up time for Foundational Community Support (FCS) trainers to provide more individualized, targeted, and intense technical assistance.

This project is critical to maintaining and improving the quality of services provided by Foundational Community Support (FCS) providers. Focused, targeted, and high-level training ensures consistency and

adherence to the evidence-based modules that Foundational Community Support uses. Currently, the Division of Behavioral Health and Recovery Foundational Community Support trainers are spending much of their time delivering stock training to providers as they onboard new staff. This type of training could easily be provided in a virtual recorded format that would free up the Foundational Community Support (FCS) trainers time to provide more advanced targeted technical assistance to providers. Freeing up the Foundational Community Support (FCS) trainers time to focus on more targeted and nuanced technical assistance allows us to grow the quality of the Foundational Community Support program.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal justice interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a way out of poverty and prevent entry into the disability system. The Individual Placement Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trails that demonstrated implementing Individual Placement Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive employment as compared to individuals not receiving Individual Placement Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

Foundational Community Supports utilizes the evidence-based practices of SAMSHA's Permanent Supportive Housing and Westat's individual placement and support. The principles of these evidence-based practices encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. These services also value and approach participants with equity, respect as well as cultural humility with the hope of promising outcomes.

Project #: BGCE-RSS19

Proposed Budget: \$500,000

*Additional \$500,000 SABG

Project Title: Cover Foundational Community Support (FCS) Services in Institution of Mental Disease (IMD) When Medicaid is Suspended

Scope:

The Division of Behavioral Health and Recovery proposes to utilize block grant funds to cover Foundational Community Support services for people transitioning out of Institution of Mental Disease (IMD) settings if the Medicaid isn't retroactively reconnected. The Foundational Community Support (FCS) program assists eligible individuals with complex health needs obtain and maintain stable housing and can provide Foundational Community Support services within short-term Institution of Mental Disease (IMD) settings with housing assessments and begin the housing acquisition process prior to discharge. These newly added services to Foundational Community Support will include coaching, advocacy, information and referral, linking and coordinating, and ongoing supports that they may not otherwise have access to.

The program offers an array of transition/pre-tenancy and tenancy-sustaining supports that have been effective in improving housing stability, health and employment outcomes for high need Medicaid beneficiaries. linking and coordinating, and ongoing supports that they may not otherwise have access to. Many of these individuals have complex health profiles and face multiple housing related barriers to effectively engaging with health care systems and managing their own plan of care to achieve improved health and wellness. Foundational Community Support have reduced the frequent use of emergency department and inpatient care, addressed significant gaps in connections to care, addressed homelessness, and now can help to facilitate timely, successful transitions from institutional settings to integration in community placements. Anticipated Outcomes:

- Effectively target interventions to eligible individuals in residential treatment settings;
- Streamline and standardize transition and tenancy-sustaining services for individuals exiting residential treatment across agencies and systems;
- optimize and braid all available funding to fill gaps;
- reduce Substance Use Disorder/Opioid Use Disorder (SUD/OD) related deaths;
- improve Substance Use Disorder system capacity; and
- improve quality of care

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is no other mechanism to reimburse Foundational Community Support providers if the individuals Medicaid is not active at the time of authorization. The Health Care Authority has taken steps to attempt to mitigate this by providing Foundational Community Support providers access to Provider One to check Medicaid eligibility. This however is not a perfect solution and there are times when Foundational Community Support providers go unpaid.

The Foundational Community Support program is based on the evidence-based practices (EBP) of Permanent Supportive Housing (PSH) and Individual Placement and Support (IPS). The principles of these Evidence-Based Practices encompass equity and racial justice through the promotion of choice, flexible voluntary services, and access.

Project #: BGCE-RSS20

Project Title: Peer Wellness Coach Training

Proposed Budget: \$15,000

*Additional \$15,000 SABG

Scope:

These funds would be used to bring either Peggy Swarbricks Wellness coaching or Pat Deegan's Person Medicine Coach certification training to Certified Peer Counselors. Pat Deegan's program can also bring a train the trainer to Washington so that we can training Certified Peer Counselors in Personal Medicine Coach training.

This project will provide continuing education to certified peer counselors in Washington State around. The intended outcome is to increase the knowledge of certified peer counselors to even more effectively support the peers they serve. Both programs focus on increased health outcomes. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors.

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors are effective in increasing recovery outcomes in mental health and Substance Use Disorder (SUD). Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors. This continued education will provide information to better support people in whole health as we are moving to a more integrated approach to who person care.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices, and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS22

Project Title: Training for Oxford Outreach Staff

Proposed Budget: \$20,000

*Additional \$20,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

DBHR currently funds 10 outreach staff that provide support to the 300+ Oxford houses in Washington State. Individuals with co-occurring SMI and SUD diagnosis are recipients of the mutual support received within an Oxford house. This proposal is to fund training for the 10 outreach staff to better support the individuals with co-occurring serious mental illness and substance use disorders. Training topics include but not limited to de-escalation, mediation, grief counseling etc.

We would like to add funding for training Oxford House Outreach Workers. There have been too many deaths in the Oxford Houses since COVID-19 started due to isolation and the feelings of hopelessness which brings an increase in drug and fentanyl use and ultimately relapses and deaths. Therefore, there is a need for the 10 Oxford House Outreach Representatives to get trainings on de-escalation, grief and loss, relapse prevention, meditation, Dialectical Behavioral Therapy (DBT), and any other training that would benefit the Oxford House Representatives in helping the residents deal with their grief, losses and fears of relapse.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Oxford House Sober Recovery Homes fills a gap in the substance use disorder services continuum by establishing and maintaining self-run, self-supported peer-operated sober recovery homes. In adherence with United States Code, Title 42, Section §300X–25 Group Homes for Recovering Substance Abusers, the State Agency will utilize the Oxford House concept to increase sober recovery housing assistance opportunities for recovering individuals living together in a residential disciplined environment to maintain recovery without recurrence of use. This level of care includes the provision of a safe and affordable home, in a drug-free living situation to recovering individuals with the support of other peers in recovery, Contractor staff, and other supports and services in the community including mental health guidance from outreach representatives who are trained.

Adult men and women completing residential treatment or are currently in outpatient treatment for substance use disorder, as well as those enrolled in recovery support, and opioid treatment services, who need a place to live and can meet the requirements for being a resident of a Recovery House. People leaving prisons and jails, Oxford House has a strong re-entry program with Department of Corrections (DOC) and does not discriminate on anyone's culture, race, or mores. Recovery housing will also include populations with a reported history of opioid use disorder (OUD) and opioid use.

Project #: BGCE-RSS23

Project Title: Participant Engagement Kits for Youth – Mockingbird

Proposed Budget: \$35,000

*Additional \$35,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice

example. This project would provide funds directly related to benefit participants in homeless outreach teams to assist individuals who are seriously mentally ill and not engaged in treatment. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

The Mockingbird Society creates, supports, and advocates for racially equitable, healthy environments that develop young people at risk of or experiencing foster care or homelessness. The Youth Advocates Ending Homelessness in Washington state report an alarming number of youth experience mental health, substance use disorders and health crisis. This includes advocates that report individuals who are experiencing medical issues that may or may not receive medical treatment. The inability to care for wounds will likely cause more server health issues or worse. Proposing funding for Mockingbird Outreach for Homeless Hygiene and wound care kits such as hand sanitizer, antiseptic, rubbing alcohol, hydrogen peroxide, ointment, band aids, gauze, and pain relievers could make the difference.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Mockingbird Society of Washington report Homeless youth lack access to medical care and often go without essential hygiene and wound care items which are not covered by Medicaid.

The Mockingbird Society creates, supports, and advocates for racially equitable, healthy environments that develop young people at risk of or experiencing foster care or homelessness.

Project #: BGCE-RSS24

Project Title: Peer Pathfinders Transition from Incarceration Pilot

Proposed Budget: \$790,000

*Additional \$790,000 SABG

Scope:

This funding will add a Certified Peer Counselor to up to five existing BH-ASO contracts for jail transition services. Adding a Certified Peer Counselor to existing jail transition services teams will increase the level of services being provided, by having a CPC connect with the individuals while they are still in jail and helping them with transition to the community. The certified peer counselor will work with individuals diagnosed with a serious mental illness, linking them to behavioral health services, including co-occurring treatment, Foundational Community Support (FCS), and other applicable services.

Multiple studies support the fact that Peer support services has significant impacts on quality of life, reducing substance use, and improving positive social supports. Studies have also identified common elements of peer support, suggesting possible processes that underlie effective peer support. Peer services include shared experiences, role modelling, and positive social support. All of which are suggested to be vital aspect of peer support and moderate positive life changes. By adding a certified peer counselor to existing Jail Transition services allows for access to these vital services for individuals with SMI and co-occurring health conditions, reducing likelihood for further court involvement. Impacts that are likely to occur if this project is not approved included recidivism because the individual was not provided the needed services during their jail transition.

Addressing State Needs and Gaps, Including Gaps in Equity:

People exiting jails are more likely to be successful when they are able to connect and engage in services in their communities upon release. Currently in some parts of the state jail transition services are only reaching jail populations a few times a month. By adding a Certified Peer Counselor to existing jail

transition services, individuals who are in need of extra support in accessing community-based services can be offered the support of a peer. These certified peer counselors would focus on linking individuals to behavioral health services, including co-occurring treatment, housing and employment, and community resources.

A disproportionate number of individuals of color are represented in our criminal court system and they experience greater barriers in accessing healthcare and community behavioral healthcare. This problem is greater amplified the further away you move from urban settings and locations in which more services are available. By adding the support of a Certified Peer Counselor to existing jail transition services, this will increase the likelihood of individuals being able to overcome some of these barriers.

Project #: BGCE-RSS25

Project Title: Add Co-Occurring Peer to F-HARPS

Proposed Budget: \$400,000

*Additional \$400,000 SABG

Scope:

These additional funds would allow the teams to hire another certified peer counselor for each Forensic HARPS team in the phase 1 regions. With this additional staff person, the teams would be able to increase caseload capacity. This position would also allow the Forensic HARPS teams to serve individuals diagnosed with serious mental illness or co-occurring.

This project is critical because it will increase the capacity of the teams to serve more eligible individuals through the Forensic HARPS program, an element of the Trueblood Settlement. Housing access, support, and short-term subsidies increase an individual's opportunity for recovery. Housing is a basic need that reduces the likelihood of recidivism in the criminal court system. If this funding is not approved, the Forensic HARPS teams will not be able to serve all those who are eligible and in need of this service.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Forensic HARPS teams have short-term housing subsidy dollars to assist participants in obtaining and maintaining housing. The amount of subsidy dollars allocated to each team is greater than what the current staffing model allows them to spend. With this additional staff person, the Forensic HARPS teams will be able to fully utilize the subsidy dollars allocated to them. Funding Forensic HARPS teams is cost effective because it diverts individuals with serious behavioral health conditions into receiving the services, they need instead of being arrested or hospitalized. Supportive housing reduces inpatient hospitalization, incarceration and engagement in outpatient treatment increases when individuals are successfully housed (RDA, FCS preliminary outcomes 2020).

Helping individuals obtain and maintain housing of their choice helps them be more successful in treatment. Forensic HARPS teams are trained in leveraging all community resources once an individual exits jail or an institutional setting, but the 'bridge subsidy' is still needed in order to assist individuals exit jail as quickly as possible.

A disproportionate number of individuals of color are represented in our criminal court system. Many of these individuals experience significant barriers in accessing safe and affordable housing. WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain

housing, increasing the number of unhoused individuals. People with trauma, a history of homelessness, and co-occurring disorders have an increased likelihood of being involved in the criminal court system. Helping individuals find and maintain housing of their choice, and obtain wanted services, especially during an increased time of hardship such as COVID-19 is our states responsibility.

Project #: BGCE-RSS32

Project Title: Operationalizing Peer Bridger

Proposed Budget: \$25,000

*Additional \$25,000 SABG

Scope:

This funding will be used to create an Operationalizing Peer Support training for the peer Bridger program for jails, hospitals and Substance Use Disorder (SUD) treatment agencies. Operationalizing Peer Support trainings provide Technical Assistance (TA) to existing and new agencies who need support with their peer program or who want to implement peer services. This training would also be to provide technical assistance to the jails, hospitals and inpatient setting who will be collaborating with the peer Bridger program.

As we transition the peer Bridger from providing services at the state hospitals into community-based hospitals and inpatient settings, technical assistance will be beneficial in the transition for the agencies, hospitals, and the peer Bridger program. If not approved, there will be confusion about the peer Bridger program and how to effectively utilize the services resulting in people not receiving these recovery support services. This could increase recidivism into an inpatient setting.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently a shortage of behavioral health workers across Washington State. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. We are currently witnessing gaps in service since the 90/180-day beds went live last year. This needed TA would be able to provide the necessary support and education to effectively utilize the peer Bridger program increasing recovery supports in inpatient settings.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS33

Proposed Budget: \$100,000

Project Title: Create a Dashboard on Healthcare for Workers with Disabilities

Scope:

Washington's Healthcare for Workers with Disabilities is the Medicaid Buy-in Program. Nothing provides 'hope' more than believing that people can work but addressing an individual's concerns about how working affects their governmental benefits is key to implementing the evidence-based practice model called Individual Placement and Support. Benefits counseling is one of the core principles of providing this EBP model. Part of benefits counseling is to help individuals access work incentives such as the Medicaid Buy-in Program to ensure working doesn't have adverse effects to their receipt of services or medications. This project would promote this untapped work incentive program/Medicaid Buy-in program through the creation of a marketing campaign and public dashboard on the utilization of the benefit. According to Research and Data Analysis in the 2nd quarter of 2020, only 12 percent of disabled individuals with a serious mental health issue were employed in Washington State. (10,631/88,381). There are currently 1606 individuals in WA on HWD.

The Apple Health for Workers with Disabilities (HWD) program recognizes the employment potential of people with disabilities and represents Washington State's response to the landmark "Ticket to Work" legislation passed by Congress in 1999. Healthcare for Workers with Disabilities (HWD) is an underutilized program within the state of Washington. This is a critical program to provide low-cost healthcare for people with disabilities, enabling people with disabilities to no longer have to choose between taking a job and having health care, and therefore work to their full potential. Marketing needs to include the message that self-sufficiency is attainable. There is a need to communicate measurements of number of individuals using the service as a part of marketing the program. This proposal is to develop a public facing dashboard as a part of marketing. There will be collaboration between the Health Care Authority departments that have Healthcare for Workers with Disabilities (HWD) as part of the service provided, with the communications department, and with Research and Data Analysis in order to come up with an attractive and fully functioning site that provides current and accurate data.

The benefit to the government is shifting individuals off of benefits and having them add to tax revenue. Under Healthcare for Workers with Disabilities, people with disabilities can earn more money and purchase health care coverage for an amount based on a sliding income scale.

Healthcare for Workers with Disabilities benefits include:

- Medicaid benefit package
- Access to long term services and supports, if functional requirements are met
- Greater personal and financial independence
- Members can earn and save more without the risk of losing their healthcare coverage

If not approved, people with disabilities have less encouragement to work and continue to live below the poverty level while remaining on public benefits. It disproportionately negatively impacts ethnic minorities.

Addressing State Needs and Gaps, Including Gaps in Equity:

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see

work as an essential part of recovery, but many avoid seeking work due to fear of losing benefits. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Results from regressions on earnings suggest that Healthcare for Workers with Disabilities (HWD) participants with prior Medicaid coverage earn substantially more than non-participants in the year following enrollment. On average, they earn roughly \$2,000 more than their contemporary peers in the following year and \$2,500 more than a historical comparison group. Healthcare for Workers with Disabilities (HWD) Participants historically rely less on Basic Food benefits.

Healthcare for Workers with Disabilities (HWD) will create and sustain a culture of respect, caring and inclusion through employment. Programs that focus on employment enhance the value and respect garnered by the individual and help them to sustain their culture in the community. It empowers them to become positive role models. Services provided are inclusive of all who need them and targeted to individuals with a range of disabilities that have become successfully employed. Outreach will address the foregoing population.

Project #: BGCE-RSS35

Project Title: Implicit Biased Training for Landlords

Proposed Budget: \$10,000

*Additional \$10,000 SABG

Scope:

This project would create a training series for landlords on Implicit Bias. Implicit bias describes our attitudes towards people or associates stereotypes with them without our conscious knowledge. Implicit Bias trainings are designed to exposed to people to their biases and provide tools to adjust automatic patterns of thinking and ultimate eliminate discriminatory behaviors.

The Division of Behavioral Health and Recovery would work in partnership with the Department of Commerce's Landlord Mitigation Project to provide training to landlords who often rent to individuals with behavioral health conditions. Training would focus on addressing and identifying implicit biases and how this could be unintendedly affecting their decision on who to rent to.

This project is important because Washington State has a serious deficit of safe and affordable housing. This means that rentals are extremely scarce, and landlords could unintendedly discriminate against people of color and people with behavioral health conditions. The anticipated outcome of this project is to help landlords identify and then address their implicit biases.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal court interactions. The research is clear—homelessness, and unstable housing contribute to poor health.

Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

A disproportionate number of individuals of color experience housing instability. Many of these individuals experience significant barriers in accessing safe and affordable housing. WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. People with trauma, a history of homelessness, and co-occurring disorders have an increased likelihood of being involved in the criminal court system. This training will educate landlords on how their implicit bias might limit who they choose to rent to.

Project #: BGCE-RSS36

Proposed Budget: \$500,000

Project Title: Funding for SSI/SSDI, Outreach, Access, and Recovery (SOAR) Leads

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance.

Scope:

SSI/SSDI Outreach Access and Recovery (SOAR) is a proven effective model to increase access to governmental benefits. This project would create a SOAR Lead Position in multiple regions/counties (scalable). SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads hold local steering committee meetings, lead SSI/SSDI, Outreach, Access and Recovery (SOAR) online course training cohorts and conduct half-day SSI/SSDI, Outreach, Access and Recovery (SOAR) online course review sessions. SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads will also be mentoring individuals who complete the SSI/SSDI, Outreach, Access and Recovery (SOAR) online course and reporting on outcomes.

This will provide increased access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a serious mental illness. Access to these benefits will help individuals stabilize their housing and health.

Addressing State Needs and Gaps, Including Gaps in Equity:

Many unhoused individuals qualify for disability benefits but have a difficult time getting through the application process. With an SSI/SSDI, Outreach, Access Recovery (SOAR) Representative assisting with the application process, individuals are approved more often and more quickly. Most landlords require some kind of monthly income, this will help provide that and allow more individuals to obtain housing.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all

programming. Programs will promote Diversity, Equity and Inclusion and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS41

Project Title: Enhance Mobile Crisis Teams with CPCs

Proposed Budget: \$1,909,000

Scope:

HCA will build upon the Transformation Transfer Initiative (TTI) crisis services continuing education curriculum for Certified Peer Counselors by piloting enhancements to mobile crisis teams by adding Certified Peer Counselors to existing teams. Funds will be issued to BH-ASOs to expand Mobile Crisis Response services serving those diagnosed with SMI/SED.

This project will provide enhance mobile crisis services by adding certified peer counselors in Washington State. The intended outcome is to increase the engagement and outreach of MCR teams to include certified peer counselors to even more effectively support the peers they serve in crisis settings.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. Expanding mobile crisis services to include Certified Peer Counselors will better support people as Washington expands peer services in crisis settings.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote DEI and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Tribal Projects Detail

Project #: BGCE-TRB3

Project Title: Funding to Tribes and Urban Indian Health Organizations

Proposed Budget: \$861,000

*Additional \$1,270,794 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Operation of an “access line,” “crisis phone line,” or “warm lines” to address any mental health issues for individuals.
- Training of staff and equipment that supports enhanced mental health crisis response and services.
- Mental Health Awareness training for first responders and others.
- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).
- Prison and jail re-entry and enhanced discharge from inpatient settings in order to reduce risks of COVID-19 transmission.
- COVID-19 related expenses for those with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED), including testing and administering COVID vaccines, COVID awareness education, and purchase of Personal Protective Equipment (PPE)

Scope:

The Health Care Authority will provide contracts to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver needed mental health services to adults and youth with SMI/SED to prevent, prepare for and respond to behavioral health gaps due to COVID within their Tribal communities. Tribes would submit a plan to implement recommended services as outlined in the NOA and allowed within the Mental Health Block Grant (MHBG) regulations. Additional Funds to Tribes \$40,993 SABG per Tribe and \$27,778 MHBG per Tribe, totaling \$68,771 for each Tribe.

This project is important because American Indian/Alaskan Native (AI/AN) and Tribal communities have been greatly affected by the COVID pandemic and the various Tribal and State Stay at Home Orders. Tribes are navigating how to operate Behavioral Health program in a virtual and semi/virtual environment. Due to the pandemic, Tribes are stating that the individuals in their communities are struggling with social isolation and a lack of treatment services due to the pandemic. There has also been limited cultural activities available for Tribal communities due to the pandemic. The historic annual Canoe Journey was canceled two years in a row with very limited ability to implement cultural programs across all Tribal communities.

Addressing State Needs and Gaps, Including Gaps in Equity:

Department of Health (DOH) reported that overdose rates have gone up over 154% during the first 6 months of the pandemic and is the highest of other communities by race/ethnicity. The statewide increase overall is 30%. The Health Care Authority needs to continue to provide resources to Tribal communities to address those diagnosed with SMI or SED for American Indian/Alaskan Native (AI/AN) in WA. Providing direct funding to Tribes and Urban Indian Health Programs (UIHPs) also honors our government-to-government relationships by partnering with Tribes to serve American Indian/Alaskan Native WA State residents.

This project directly supports Diversity, Equity and Inclusion (DEI) by providing needed services to the American Indian/Alaskan Native (AI/AN) population in providing culturally appropriate services. This also honors our unique Government-to-Government (G2G) relationships with Tribal governments and our partnership with Urban Indian Health Programs (UIHPs).

Crisis Services:

Tribes and Urban Indian Health Programs (UIHPs) may provide crisis services with these funds. The Health Care Authority will pass down National Guidelines to Tribes to provide guidance on best practices for crisis services.

Project #: BGCE-TRB4

Project Title: Traditional Healing Pilot Project

Proposed Budget: \$100,000

*Additional \$100,000 SABG

Scope:

The Health Care Authority will contract with the Seattle Indian Health Board (SIHB) to (1) document best practices (including practice and administrative tools) for an Indian Health Care Provider (IHCP) to offer traditional healing/traditional Indian medicine (TIM) services, and (2) analyze the health outcomes and potential cost savings from offering Traditional Indian Medicine (TIM) services. TIM can serve individuals with SMI/SED and substances use disorder, alongside Western based strategies for the prevention, treatment, and recovery of SMI/SED/SUD. TIM can also help with SMI/SED/SUD prevention. The services may include storytelling, talking circles, drumming, sweat lodge, prayers, blessings (such as cleansing and smudging), etc. TIM services are provided by a community-verified practitioner of TIM. Please note that this grant will not pay for actual TIM services. The Seattle Indian Health Board (SIHB) deliver the following to the Health Care Authority:

1. Recommendations for billing, coding and reimbursement models for Traditional Indian Medicine (TIM) services.
2. Analysis, recommendations, and examples of charting for Traditional Indian Medicine (TIM) services and incorporation of charting into an Electronic Health Record (EHR).
3. Recommendations and analysis on best practices for incorporating Traditional Indian Medicine (TIM) practitioners into integrated care teams.
4. Recommendation and analysis for privileging and credentialing standards of Traditional Indian Medicine (TIM) practitioners and apprentices.
5. Evaluation and analysis of the health outcomes for individuals and populations receiving the Traditional Indian Medicine (TIM) services. Measures could include:
 - Number of services completed;
 - Impacts on health outcomes;
 - Policy analysis;
 - Estimated costs of encounters;
 - Cost benefit analysis;
 - Comparison of the population that receives Traditional Indian Medicine (TIM) and the population that does not;
 - Comparison of patient's perception of their health pre-Traditional Indian Medicine (TIM) services and post-Traditional Indian Medicine (TIM) services, etc.

These items will be submitted as separate reports and guidance documents that will be available for the Health Care Authority, federal partners and other Indian Health Care Providers and Tribes in providing technical assistance on integrating Traditional Indian Medicine (TIM) into health programs with a focus on the treatment and recovery of Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

The Washington Indian Health Care Improvement Act, passed by the state legislature in 2019, had three main goals:

1. Provide resources to ensure the highest possible health status of American Indians/Alaska Natives (AI/AN) in Washington;
2. Raise the health status of American Indian/Alaskan Native (AI/AN); and
3. Ensure tribal self-determination in the areas of health care services.

One recommendation coming out of the Act was the expansion of traditional Indian medicine (TIM). This project helps the Health Care Authority to honor this key recommendation. Traditional Indian Medicine (TIM) services provide unparalleled support for American Indian/Alaskan Natives individuals struggling with severe mental illness or severe emotional disturbances and Western medicine has proven to not be appropriate for treatment and recovery supports for these American Indian/Alaskan Native (AI/AN) individuals. The anticipated outcome is documentation of positive health outcomes for individuals receiving Traditional Indian Medicine (TIM) and guidance to other Indian Health Care Providers (IHCP) on how to incorporate Traditional Indian Medicine (TIM). If not approved, we will continue to have a lack of literature available to demonstrate positive health outcomes or cost saving of these services for American Indian/Alaskan Native (AI/AN) and therefore, continue to struggle in finding sustainable funding.

Addressing State Needs and Gaps, Including Gaps in Equity:

The WA State Department of Health has found that American Indian/Alaska Native (AI/AN) overdose fatality rates have gone up 154% during the COVID pandemic. There is a known gap in the provision of culturally appropriate services for American Indian/Alaskan Natives (AI/AN) in the state of Washington and at a national level. Tribes and Indian Health Care Providers (IHCPs) are the experts in providing culturally appropriate services; however, Traditional Indian Medicine (TIM) does not have a sustainable funding mechanism. There are many evidence-based practices (EBP) available for Mental Health services; however, there are limited studies with American Indian/Alaskan Natives (AI/AN). Tribes and Indian Health Care Providers (IHCPs) find that implementing Evidence-Based Programs do not always work for American Indian/Alaskan Native (AI/AN) individuals and Tribal communities. This project will seek to develop evidence related to the efficacy of Traditional Indian Medicine (TIM) services for American Indian/Alaskan Natives (AI/AN) suffering from severe emotional disturbance or severe mental illness.

This project directly addresses Diversity, Equity and Inclusion (DEI) principles by providing support for Traditional Indian Medicine (TIM) and integration with clinically based health care. For decades, the response to Traditional Indian Medicine (TIM) is there is a lack of clinical data associating Traditional Indian Medicine (TIM) with better health outcomes. This pilot project will provide guidance around integration of Traditional Indian Medicine (TIM) and clinically based primary care and preliminary data to build the case for Traditional Indian Medicine (TIM). The intent is to provide foundational research and evidence that will support a request for sustainable Medicaid reimbursement for Traditional Indian Medicine (TIM).

Crisis Set-Aside Projects Detail

Project #: BGCE-ASO2

Proposed Budget: \$1,346,000

Project Title: Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding for Crisis Services

Scope:

Funding directed to the Behavioral Health Administrative Service Organizations (BH-ASO's) will support their respective provider networks enhancing the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. Funding will be used to enhance existing Crisis Services provided 24 hours a day, seven days a week including crisis call line, evaluation and treatment services for Individual's ineligible for Medicaid, including involuntary inpatient services, voluntary inpatient services, crisis stabilization services, Employment and Training (E&T) services, and services for the priority populations defined per Contract. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retention issues that have increased throughout the behavioral health delivery system during the pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that

policies and procedures have had different negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation. Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based mental health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health and substance use crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments; and strategies to reduce the fragmentation of mental health care.

Washington

COVID-19 Supplemental Funding Plan for FY21

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

Center for Mental Health Services
Division of State and Community Systems Development

Mental Health Block Grant COVID Supplemental Funding Plan

WA State Summary

The COVID-19 pandemic has had a significant impact on people with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) in Washington State. During the first half of 2019, 8.2% of adults over 18 years of age had symptoms of anxiety disorder and 6.6% had symptoms of depressive disorder. By comparison, in the most recent Household Pulse Survey from the Centers for Disease Control examining trends from February 17, 2021 to March 1, 2021, this prevalence quadrupled to 33.4% for anxiety and 27.7% for depression (in Washington state, rates were slightly higher with 34.2% for anxiety, 14th highest of the 50 states, and 27.8% for depression, 23rd highest of the 50 states). The age group with the highest prevalence rates nationally is 18–29-year-olds (47.2% reporting anxiety, and 42.2% reporting depression). The devastating impacts of the COVID-19 pandemic have clearly impacted young adults' mental health and substance use (a population already at high risk).

As the state and nation emerge from early Phases of the pandemic, the resulting impacts of the last year are a salient concern. People face potentially new obstacles such as continued mental health issues, overcoming the potential disruptions in school, work, and finances, and re-engaging in social life with continued recommendations from the CDC and local health departments (e.g., mask mandates). This is a critical time to address potential harms and to encourage engagement in both adaptive coping behaviors and unique strategies of social engagement within current public health guidelines to reduce high-risk substance use and worsening mental health symptoms, in both adults and youth.

HCA's Division of Behavioral Health and Recovery has reviewed the *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* and allocated a percentage of the total potential COVID-19 relief supplemental funding to address principles focused on recovery needs, support for the behavioral health workforce, particularly of Peers and Recovery Support Peers, and trauma-informed treatment services. The budget summary, on the following pages, provides the detailed amounts allocated across the continuum of behavioral health services through a wide variety of projects, treatment funds provided through our Behavioral Health Administrative Service Organizations (BH-ASO's) and Tribes. WA Health Care Authority, with input from partners, including the Behavioral Health Advisory Council, respectfully submits the proposals you will find in the pages to follow.

As part of our effort to seek stakeholder input, the Behavioral Health Advisory Council co-hosted a meeting with the Health Care Authority to invite input from various partners and representatives from across the state's behavioral health system (from Peers to school districts, as well as counties, managed care organizations and others). Input on the proposals was received at the end of the event, which helped to inform the direction, as well as solidify the allocations to each section and confirm what flexibilities to seek within the application for these COVID-19 relief supplemental funds. In addition to waiver flexibilities, the Health Care Authority may also require some flexibility to move allocations from one proposal, to another, within those in this application, in the event a particular proposal is particularly successful and requires funding allocation from another proposal which may not require the entire allocation presented in this application.

Within the budget summary below, you will find the proposed project titles, a brief description and number for each project under the sections of First Episode Psychosis, Treatment, Recovery Support Services and Crisis Services. In the pages that follow, a longer project narrative will include the project title, budgeted amount, a description, or scope of work summary, as well as a narrative of how the project addresses state needs and gaps, especially gaps in equity.

WA is grateful to SAMHSA for the opportunity to apply for the COVID-19 relief supplemental funds, as this has been an unprecedented year of extreme stressors to the most vulnerable among us, and the funding will undoubtedly support those persons at greatest risk, as well as those who seek support in treatment and ongoing recovery.

Project List and Budget Table

FEP Set-Aside			
Project #	Project Title	Project Description	Proposed Budget
Project #: BGCE-CYF7	Rural and AI/AN Pilot Project for FEP	Develop and adapt evidence based coordinated specialty care programs for FEP to meet the needs of rural, frontier and AI/AN communities.	\$ 2,307,000
Total FEP Set-Aside			\$ 2,307,000
Treatment			
Children, Youth and Family Treatment Funding			
Project #	Project Title	Project Description	Proposed Budget
Project #: BGCE-CYF2	Developing Wraparound and Intensive Services (WISe) Workforce Support	Developing Wraparound and Intensive Service (WISe) workforce to support youth with Intellectual Disabilities/Developmental Disabilities (including Autism Spectrum Disorder (ASD)).	\$ 200,000
Project #: BGCE-CYF5	Trauma Focused Cognitive Behavioral Therapy Training	Trauma Focused Cognitive Behavioral Therapy (CBT) Training for clinicians serving children and youth returning to school as part of the triage process post screening.	\$ 376,671
Adult Treatment Funding			

Project #: BGCE- MHA1	Cognitive Behavioral Therapy for Psychosis	Expansion of current contract to deliver Cognitive Behavioral Therapy for Psychosis to a cohort of clinicians who are serving people on 90/180 involuntary civil commitment orders.	\$ 130,000
Project #: BGCE- MHA2	Trauma Informed Care for Designated Crisis Responders	Modify curriculum of Trauma Informed Care training specifically for Designated Crisis Responders to incorporate the skills into their practice.	\$ 50,000
Project #: BGCE- MHA3	Mental Health Specialist Training	Develop a curriculum for a 100-hour course for Mental Health (MH) professionals to secure credentials to become an Older Adult Mental Health Specialist, Intellectual Disabilities /Developmental Disabilities (ID/DD) Mental Health Specialist, and Ethnic Minority Mental Health Specialist.	\$ 396,329
BH-ASO Treatment Funding			
Project #: BGCE- ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding	The community mental health services provided include but are not limited to outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, residents of the service areas who have been discharged from inpatient treatment at a mental health facility, day treatment or other partial hospitalization services, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, or ready for discharge from inpatient psychiatric care, and individuals residing in rural areas.	\$ 6,150,372
Total Treatment			\$ 7,303,372
Recovery Support Services			
Project #	Project Title	Project Description	Proposed Budget

Project #: BGCE- RSS1	Participant Support Funds- Housing and Recovery through Peer Services (HARPS) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	50,000
Project #: BGCE- RSS2	Participant Support Funds- Projects for Assistance in Transition from Homelessness (PATH) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	140,000
Project #: BGCE- RSS3	Participant support Funds - Peer Bridger	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	100,000
Project #: BGCE- RSS7	Certified Peer Counselor (CPC) Online Continuing Education Bank	Create online Certified Peer Counselor (CPC) continuing education trainings.	\$	50,000
Project #: BGCE- RSS8	Foundational Community Support Supported Housing/Supported Employment (SH/SE) 'fidelity reviewer certification'	Creating a Supported Housing (SH) fidelity certification development/Individual Placement and Support (IPS) certification through Westat.	\$	50,000
Project #: BGCE- RSS9	Community Work Incentive Coordinator (CWIC) training and staffing costs for a provider to attend the training	Training for Foundational Community Support service providers to become Community Work Incentive Coordinator (CWIC) trained - https://vcu-ntdc.org/training/introductory/introindex.cfm	\$	50,000
Project #: BGCE- RSS10	Intentional Peer Support Training	Train Certified Peer Counselors in Intentional Peer Support.	\$	150,000
Project #: BGCE- RSS12	Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams	Targeted peer outreach on Project for Assistance in Transition from Homelessness (PATH) teams focusing on a by-name list of individuals who have had multiple contacts with crisis system.	\$	1,120,000

Project #: BGCE-RSS13	Creating a Behavioral Health (BH) Housing Action plan	Inventory of all the housing needs of the Behavioral Health (BH) population.	\$	15,000
Project #: BGCE-RSS14	Creating a housing inventory/estimator/calculator	Provide timely information for individuals with behavioral health conditions to access housing services and resources.	\$	150,000
Project #: BGCE-RSS15	Peer Dashboard	Extract data out of the peer credential data system to have a dashboard.	\$	100,000
Project #: BGCE-RSS17	White paper/Toolkits/Medicaid Academy for Peer Run-Peer Operated Agencies	Creating a white paper on Community Behavioral Health Associate (CBHA) Lite licensing.	\$	15,000
Project #: BGCE-RSS18	Foundational Community Support - Converting Current Training to Online Training Modules	Convert Foundational Community Support training to online training modules.	\$	50,000
Project #: BGCE-RSS19	Cover Foundational Community Support Services in Institution for Mental Disease (IMD) when Medicaid is Suspended	Utilize block grant funds that would cover Foundational Community Support services for people transitioning out of Institution for Mental Disease (IMD) settings if Medicaid does not get retroactively reconnected.	\$	500,000
Project #: BGCE-RSS20	Peer Wellness Coach Training	Peer Wellness Coach continuing education curriculum developed.	\$	15,000
Project #: BGCE-RSS22	Training for Oxford Outreach Staff	De-escalation, mediation, basic grief counseling training for 10 Oxford outreach staff.	\$	20,000
Project #: BGCE-RSS23	Participant Engagement Kits for Youth - Mockingbird	Mental Health Block Grant (MHBG) & Substance Abuse Block Grant (SABG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	35,000

BGCE-RSS24	Peer Pathfinders Transition from Incarceration Pilot	Enhance jail transition programs with SUD peers services to individuals who upon release will be homeless. SUD Peer Services begin prior to release to establish relationship and upon release to support the transition to needed services.	\$ 790,000
BGCE-RSS25	Add Co-Occurring Peer to Forensic-Housing Housing and Recovery through Peer (F-HARPS) Services	Add 1 peer to each of the four Forensic-Housing Housing and Recovery through Peer Services (F-HARPS) in Phase I regions.	\$ 400,000
Project #: BGCE-RSS32	Operationalizing Peer Bridger	Create an operationalizing Peer Bridger program for hospitals, Substance Use Disorder (SUD), and Treatment (TX) agencies.	\$ 25,000
Project #: BGCE-RSS33	Create a Dashboard on Healthcare for Workers with Disabilities (HWD)	Public facing dashboard/Marketing on the number of people using the Medicaid buy-in program.	\$ 100,000
Project #: BGCE-RSS35	Implicit Biased Training for Landlords	Braid funding with Commerce to create a training for landlords.	\$ 10,000
Project #: BGCE-RSS36	Funding for SSI/SSDI Outreach, Access, and Recovery (SOAR) Leads	Helping individuals with the creation of a Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) outreach access and recovery community coordinators.	\$ 500,000
BGCE-RSS41	Enhance Mobile Crisis Teams with CPCs	Pilot enhancements to mobile crisis teams by adding CPCs to existing teams.	\$ 1,909,000
Total Recovery Support Services			\$ 6,344,000
Tribal			
Project #	Project Title	Project Description	Proposed Budget

Project #:	BGCE-TRB3	Grants to Tribes and Urban Indian Health Organizations	Provide grants to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver Substance Use Disorder (SUD) prevention, treatment, Opioid Use Disorder (OUD) intervention and recovery support services within their Tribal communities.	\$	861,000
Project #:	BGCE-TRB4	Traditional Healing Pilot Project	Indian Health Care Provider (IHCP) to offer traditional healing/traditional Indian medicine (TIM) services and analyze the health outcomes and potential cost savings from offering Traditional Indian Medicine (TIM) services.	\$	100,000
Total Tribal				\$	961,119
Crisis Set-Aside					
Project #	Project Title	Project Description	Proposed Budget		
Project #:	BGCE-ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding - Crisis Services	Services include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responders (DCR) services.	\$	1,346,000
Total Crisis Set-Aside				\$	1,346,000
TOTAL SABG Covid Supplement Budget					
FEP Set-Aside				\$	2,307,000
Treatment				\$	7,303,372
Recovery Supports Services				\$	6,344,000
Tribal				\$	961,000
Crisis Set-Aside				\$	1,346,000
Administrative				\$	961,000
Total Budget				\$	19,222,372

First Episode Psychosis Project Detail

Project #: BGCE-CYF7

Project Title: Rural and AI/AN Pilot Project for FEP

Proposed Budget: \$2,307,000

Scope:

Develop and adapt evidence based coordinated specialty care (CSC) programs for first episode psychosis (FEP) to meet the needs of rural, frontier and AI/AN communities. The project would be to help to develop a rural and /or Tribal New Journeys/CSC model, to evaluate it, and broadly disseminate the results to inform future program development. Other states are also interested in figuring out how to develop CSC services in rural areas and Tribal communities. There could be great value in collaborating with partners in other states on this (they would fund their own program development) and could help to define rural and AI/AN CSC in other parts of the U.S.

This work is critical to accomplish the legislative mandate in SSSB 5903 requiring statewide expansion of treatment for FEP. Specialized knowledge and adaptation is essential to meet the unique needs of sparsely populated regions and minority communities in order to achieve the goal of decreasing the duration of untreated psychosis. Considering the magnitude of the impact of schizophrenia, interventions designed to treat the disorder effectively at the earliest possible point (e.g., during the first episode of psychosis) have the potential to improve its long-term trajectory, improve outcomes, improve lives, save lives and save health care dollars and to reduce the health care burden of the illness. The longer a person goes untreated, the more severe and chronic their symptoms become, often resulting in decreased functioning and other negative outcomes over their lifetime.

Addressing State Needs and Gaps, Including Gaps in Equity:

Initial examination of 2018 Medicaid data indicate that extra support is needed to ensure that intervention with first episode is equally available in rural geographical areas and in AI/AN communities. The data suggest there are existing geographical disparities and AI/AN disproportionality. The Washington State Legislature, Children's & Youth Behavioral Health work group (CYBWHG) and SAMSHA have all prioritized early identification and intervention for psychosis. This is so screening and early identification of psychosis among adolescents and young adults will become a universal health care practice, and evidence-based recovery interventions will be available to those who need them.

Treatment Projects Detail

Children, Youth and Family

Project #: BGCE-CYF2

Project Title: Developing WISE Workforce Support

Proposed Budget: \$200,000

Scope:

Developing Workforce & Enhancing Local Care Networks to support Youth with Intellectual or Developmental Disabilities including Autism Spectrum Disorder
Three lead Wraparound and Intensive Services (WISE) behavioral health agencies will plan and implement the project informed by local needs with logistical oversight provided the Wraparound and Intensive Services (WISE) Workforce Collaborative/En Route. A training component will be provided by Seattle Children's Autism Center and offered to a total of five (5) Behavioral Health agencies. The proposed RUBI training model will include:

- (1) An initial 16-hour workshop attended by all WISE team providers;
- (2) 20 weeks of ongoing consultation with the WISE team mental health therapist
- (3) Fidelity review of WISE therapist implementation of RUBI sessions

Agencies selected will have been involved in the Health Care Authority and Developmental Disabilities Administration (DDA) convened Wraparound and Intensive Services (WISE) and Intellectual Disabilities/Developmental Disabilities (ID/DD) and Autism Spectrum Disorder (ASD) workgroup or Project Echo sessions. This allows the project to build more directly on the knowledge and efforts already in process.

The three lead agencies will dedicate a portion of a staff time to participate in developing the specialty team model, attend training, learning collaboratives and consultation. Lead sites will also convene community partners to plan for enhancing their local care network to support youth with Intellectual Disabilities/Developmental Disabilities (ID/DD) and Autism Spectrum Disorder (ASD).

Wraparound with Intensive Services (WISE) provides intensive home and community based mental health services to Medicaid eligible children and youth, in compliance with Title XIX of the federal Social Security Act. WISE is available for children and youth 20 years of age or younger who have a serious mental illness.

To receive WISE a child or youth is 1) Medicaid eligible, 2) has a mental health diagnosis and 3) meets the WISE screening algorithm. The WISE screen is to help determine if the youth needs this intensive level of outpatient care.

By design, WISE is a service delivery model for children and youth with the most complex mental health challenges in Washington state. WISE provides individualized, culturally competent services that strive to keep youth with intense mental health needs safe in their own homes and communities, while reducing unnecessary hospitalizations. WISE offers a higher level of care through these core components:

- The Time and Location of services: WISE is community-based. Services are provided in locations and at times that work best for the youth and family, such as in the family home and on evenings and weekends.

- Team-based Approach: Each WISE team includes youth, family members, a WISE care coordinator, a therapist, a Certified Peer Counselor, includes natural supports and members from other child-serving systems when they are involved in a youth's life.
- Help during a crisis: Youth and families have access to crisis services any time of the day, 365 days a year. Youth receive services by individuals who know the youth and family's needs and circumstances, as well as their current crisis plan.

Intensive services provided in WISE include but are not limited to:

- Individual treatment services
- Family therapy services
- Psychiatric medication services
- Crisis mental health services—Outreach services
- Recovery support—Wraparound facilitation services
- Peer support services

References:

- The program, policy and Procedure manual can be found here [WISE Manual](#) and the WISE screening algorithm is available on page 75
- WISE meets the criteria established in the Children's Mental Health Lawsuit under obligations set forth in the [T.R. Settlement Agreement](#)
- [HCA WISE webpage](#)

Addressing State Needs and Gaps, Including Gaps in Equity:

During COVID the increased need of trained staff to provide stabilization support for youth in Wraparound and Intensive Services (WISE) with Intellectual Disabilities/Developmental Disabilities (ID/DD) including Autism Spectrum Disorder (ASD) has become apparent. The concern identifying the need for additional training has been expressed by caregivers, behavioral health agency staff and allied system partners. Our behavioral health workforce is often times generalists by education and don't have the training to best support youth with Autism Spectrum Disorder (ASD) and their families. This funding would provide the training support and consultation to five behavioral health agencies as well as enhance community coordination in three regions for youth enrolled in Wraparound and Intensive Services (WISE) with Intellectual Disabilities/Developmental Disabilities including Autism Spectrum Disorder.

The community coordination and development of this project would include outreach to BIPOC communities to participate and provide insight to specific community needs.

Project #: BGCE-CYF5

Project Title: Trauma Focused Cognitive Behavioral Therapy Training **Proposed Budget:** \$376,671

Scope:

Provide training in Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) to clinicians serving children and youth returning to school as part of the triage process post screening as a part of the recommended Department of Health fast response plan to help meet the needs of children and youth returning to school following the Governor's proclamation that in person options are required as of April 1, 2021. This will serve youth who indicate trauma exposure in the screening process (SED). This is following the Sonoma model, and will further enhance the clinical interventions available to children and youth across WA in the long run.

The Governor issued a proclamation that in person options be available across WA as of April 1, 2021. The potentially unmet needs of children and youth over the past year regarding mental health impact are expected to surface as children youth and families begin the transition to in person education. This proposal meets an identified need in the plans to date that matches the requirements of this funding.

Addressing State Needs and Gaps, Including Gaps in Equity:

The workforce serving children youth and families across Washington are dedicated to the age group and the developmentally appropriate interventions needed. This training further supports them in an evidence-based response to the expected wave of trauma exposure from impacts of the pandemic, to support and serve with resilience and strength-based approaches and supports in pushing back compassion fatigue in ensuring they have the tools they need to feel effective in their work, resulting in resilient communities.

Efforts will be made to ensure training is offered to diverse clinician groups including BIPOC and LGBTQ+ clinician groups.

Adult Treatment

Project #: BGCE-MHA1

Project Title: Cognitive Behavioral Therapy for Psychosis

Proposed Budget: \$130,000

Scope:

This project will expand upon our current contract with the University of Washington's Supporting Psychosis Innovation through Research, Implementation and Training (SPIRIT) Lab to deliver Cognitive Behavioral Therapy for Psychosis to a cohort of outpatient and inpatient clinicians from selected

contracted community-based sites who are serving people receiving 90/180 involuntary civil commitment orders. This Evidence Based Practice (EBP) helps people living with psychosis achieve a level of self-management that has shown great success, supporting individuals and their families in the community.

Many of the people on these long-term involuntary commitments experience psychosis so this Evidence Based Practice is a good fit for the needs of this population. We will train two cohorts of clinicians- each cohort containing staff from an inpatient setting serving people on 90/180 involuntary civil commitment orders and a corresponding outpatient behavioral health agency that treats these individuals upon discharge- or may have treated the individual prior to admission. This will allow the skills learned in either setting to be supported and reinforced in the other setting. The plan is to first train the clinicians to a level of competency such that they then can be trained to supervise others with the model. It would then broaden to be delivered in group treatment and then be the model of treatment across the milieu for those in inpatient settings. We believe that this implementation plan should have good sustainability for these sites.

Training outpatient behavioral health agency staff and their locally corresponding contracted long term civil commitment sites in an appropriate Evidence Based Practice should assist this population in better managing their symptoms and reduce their need for further involuntary or inpatient treatment. This recovery-based model supports both the individual and their family which should help individuals to successfully remain in the community.

Addressing State Needs and Gaps, Including Gaps in Equity:

Training our Behavioral Health workforce in Cognitive Behavioral Therapy (CBT) for Psychosis will help empower individuals living with psychosis to better manage symptoms that interfere with their ability to live their lives in the community. The Behavioral Health workforce needs enhanced tools to treat psychosis beyond simply medication alone. This evidence-based practice is targeted to the needs of a population that traditionally does not receive therapy as many clinicians do not know about Cognitive Based Therapy (CBT) for Psychosis and its success rate. Additionally, the facilities that have begun to take individuals on long term orders have reported a need for more enhanced programming for this population and it is important to provide continuity of care, including support for skills development, across care settings.

People living with psychosis experience much social isolation due to their symptoms. By providing them with greater skills to manage psychosis, this inequity will be better addressed. This enhancement will serve all populations living with psychosis, including members of BIPOC communities but is not a targeted outreach to them specifically.

Project #: BGCE-MHA2

Project Title: Trauma Informed Care for Designated Crisis Responders **Proposed Budget:** \$50,000

Scope:

Modify curriculum of Trauma Informed Care Training specifically for Designate Crisis Responders so that Designated Crisis Responders (DCR) can incorporate the skills into their practice. Conducting involuntary treatment investigations can be innately traumatizing. Incorporating trauma informed techniques into the Designative Crisis Responder (DCR) skill set can help make the investigations less traumatizing, and hopefully minimize long term trauma from the involuntary treatment process.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently no trauma informed care training specific to the work Designative Crisis Responders do. Involuntary Treatment Act (ITA) evaluations can be traumatizing for the people performing the evaluation. To minimize the impact to the Designated Crisis Responders, the individuals being evaluated and the system as a whole, this training is immediately necessary.

Individuals in BIPOC communities and those with serious behavioral health issues are more likely to have encounters with law and healthcare systems that result in furthering trauma. The trauma that effects the individual being evaluated also impacts the person doing the evaluation. Proper training can help improve the interactions between Designated Crisis Responders, law enforcement and individuals receiving treatment. This will assist in more sustainable recovery for every individual, and a system prepared to support those in need.

Project #: BGCE-MHA3

Project Title: Mental Health Specialist Training

Proposed Budget: \$396,329

Scope:

Develop curricula for a 100-hour course for Mental Health Professionals who provide treatment services to individuals with SMI or SED to secure credential to become an Older Adult Mental Health Specialist, Intellectual Disabilities/Developmental Disabilities (ID/DD) Mental Health Specialist, and Ethnic Minority Mental Health Specialist as defined in Washington's Rehab State Plan for Mental Health Outpatient (OP) treatment. Training curricula will focus on recognizing unique needs of these populations, clinical best practices, understanding of the community resources and partners when working with these populations, the role of Mental Health Specialist and how to provide clinical consultation, cultural humility, and other relevant information specific to each demographic.

The Division of Behavioral Health and Recovery (DBHR) has not sponsored Mental Health Specialists academies for almost ten years and as such, there are significant workforce shortages in specialists trained and credentialed to work with the older adult population, individuals with intellectual and developmental disabilities, and ethnic minorities. Each of these populations has unique needs or considerations that impact care and the behavioral health workforce needs additional training and supports in order to meet their needs. The overall intent is to provide better care for clinicians who provide services to SMI and SED populations.

Addressing State Needs and Gaps, Including Gaps in Equity:

With a fast-growing aging population, the need for mental health professionals trained and sufficiently skilled to work with older adult population is more critical than ever. The current workforce requires

specialized skills and knowledge to better support BIPOC populations and people with Intellectual Disabilities/Developmental Disabilities. This is a work force shortage that must be addressed.

BIPOC communities, older adults, and people with Intellectual Disabilities/Developmental Disabilities must receive culturally appropriate services from clinicians with relevant education, experience, and skills. This is a matter of equity and parity.

BH-ASO Treatment Funding

Project #: BGCE-ASO2

Project Title: Behavioral Health Administrative Services Organization (BH-ASO) Treatment Funding
Proposed Budget: \$6,150,372

Scope:

Funding directed to the Behavioral Health Administrative Services Organizations (BH-ASO) will support their respective provider networks enhancing the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. This includes a regionally based system of care that includes mental health services to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities. Including increasing capacity of Designated Crisis Responder (DCR) and Tribal Designated Crisis Responder (DCR) services.

The community mental health services are provided to individuals with serious mental illness/serious emotional disturbance including specialized outpatient services for American Indian/Alaskan Native (AI/AN), children, and the elderly. Services provided include but are not limited to outpatient services for individuals who have been **discharged** from inpatient treatment, day treatment, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, and individuals residing in rural areas. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retainment issues that have increased throughout the behavioral health delivery system during the pandemic.

If funding were not approved the statewide behavioral health service delivery system will continue to face funding gaps, service delivery delays, and individuals diagnosed with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) will be less likely to have opportunities to access services and function better in their communities experiencing an improved quality of life. Further, an opportunity to

enhance and improve ongoing behavioral health system workforce recruitment and staff retention worsened by the pandemic will be missed.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support, and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that policies and procedures have had negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation.

Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based behavioral health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments.

Recovery Support Services Projects Detail

Project #: BGCE-RSS1

Project Title: Participant Support Funds – Housing and Recovery through Peer Services (HARPS) Teams
Proposed Budget: \$50,000

*Additional \$50,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice example. This project would provide funds directly related to benefit participants in the HARPS program to assist individuals who are transitioning from inpatient settings to the community. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

We expect the housing crisis and behavioral health crisis to intensify as eviction protections are lifted. The Housing and Recovery through Peer Support (HARPS) priority population is unable to earn wages while involved with inpatient treatment and is unlikely to have savings to secure housing upon discharge. Additionally, many participate intensive outpatient treatment which limits the amount of time to earn wages to afford housing, as well as other necessities to stay engaged in treatment and recovery activities.

Adding additional support funds to each Housing and Recovery through Peer Services (HARPS) contract to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination of other healthcare services and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Participant Support Funds will help the Housing and Recovery through Peer Support (HARPS) Teams to interweave care coordination, case management, and outreach services. People experiencing homelessness and behavioral health conditions benefit from connections to peer services and resources.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS2

Project Title: Participant Support Funds – Projects for Assistance in Transition from Homelessness (PATH) Teams
Proposed Budget: \$140,000

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice example. This project would provide funds directly related to benefit participants in the homeless outreach teams to assist individuals who are seriously mentally ill and not engaged in treatment. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

Proposed support service funds will be added to the current contracted programs, Projects for Assistance in Transition from Homelessness (PATH). PATH programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency will be required to develop a detailed plan describing method and intended outcome for allocating client support service funding and submit to the Health Care Authority for approval by 09/30/2021. Plan must be based on Mental Health Block Grant (MHBG) guidance for Target Population* and Statement of Work.

Persistent and consistent outreach and providing services at the individual's pace are important steps to engage people with serious mental illness who are homeless. The proposed support service funds will enhance the quality of program delivery and engagement and expand critical client resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

Homeless outreach services intention is to reach individuals who are not currently engaged in services and potentially unable to navigate the system. The ability to have support services that offer basic needs upon engagement increases the likelihood for engagement in treatment and recovery.

PATH teams serve individuals experiencing homelessness and Serious Mental Illness (SMI) to BIPOC communities. BIPOC communities are overrepresented in homelessness. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: BGCE-RSS3

Project Title: Participant Support Funds – Peer Bridger
Proposed Budget: \$100,000

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

- COVID-19 related expenses for those with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED), including testing and administering COVID vaccines, COVID awareness education, and purchase of Personal Protective Equipment (PPE).

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice example. This project would provide funds directly related to benefit participants with serious mental illness who are transitioning from inpatient settings to the community. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

The goal of this project is to use participant funds to connect people to community supports and treatment and reduce recidivism to the state hospital admissions. Keeping individuals engaged in peer services creates personal connection, accountability, and someone to assist in navigating complicated systems. Without these added supports the system continues to be a revolving door for many.

MHBG Funds could be used to support case managers, outreach workers, Assertive Community Treatment Services For people experiencing homelessness, medications, coordination with primary care, and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support improves engagement and increases hope by modeling recovery. These complimentary services will enhance the already proven Peer Bridger model.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS7

Project Title: Certified Peer Counselor (CPC) Online Continuing Education Bank

Proposed Budget: \$50,000

*Additional \$50,000 SABG

Scope:

This funding would be used to create online Certified Peer Counselor (CPC) continuing education trainings. The trainings could include Wellness Recovery Action Plans (WRAP), Crisis Plans, Suicide Prevention, cultural awareness, and others. The goal is to great online learning bank for Certified Peer Counselors where they can access continuing education trainings on demand.

These trainings would be accessible for all certified peer counselors in Washington and the knowledge gained will improved peer services provided in Washington. Traditionally Certified Peer Counselors (CPCs) continuing education trainings have been funded by DBHR, during the past year we have had to reallocate funding to meet the needs of the Certified Peer Counselor workforce by increasing our core Certified Peer Counselor (CPC) trainings. These online trainings will be able to be accessed by peers across the state no matter where they reside or work and removing barriers to access. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors (CPCs).

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors (CPCs) are effective in increasing recovery outcomes in mental health and Substance Use Disorder (SUD). Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors. Continuing education for certified peer counselors is always requested and providing these trainings in a virtual format will make the trainings more accessible to peers in all areas of the state.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS8

Project Title: Foundational Community Support (FCS) Supported Housing/Supported Employment (SH/SE) Fidelity Reviewer Certification

Proposed Budget: \$50,000

*Additional \$50,000 SABG

Scope:

Intensive Trainings for Foundational Community Supports (FCS) providers to increase their skills/trainings on SAMSHA Permanent Supportive Housing (PSH) Fidelity Reviews and Individual Placement and Support (IPS) Support Employment Fidelity Reviews.

Washington State Foundational Community Support programs uses two evidence-based models- SAMSHA Permanent Supportive Housing and WESTAT/Rockville Institutes Individual Placement and Support Supported Employment Model. To ensure high quality standards and fidelity to these models, Foundational Community Support (FCS) providers participate in fidelity reviews. This funding will allow Foundational Community Support provider to participate in intensive training to able to provide high quality fidelity reviews and ensure compliance with the evidenced based practices.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal justice interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a way out of poverty and prevent entry into the disability system. The Individual Placement and Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trails that demonstrated implementing Individual Placement and Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive employment as compared to individuals not receiving Individual Placement and Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement and Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

Foundational Community Supports utilizes the evidence-based practices of SAMSHA's Permanent Supportive Housing and Westat's individual placement and support. The principles of these evidence-based practices encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. These services also value and approach participants with equity, respect as well as cultural humility with the hope of promising outcomes.

Project #: BGCE-RSS9

Proposed Budget: \$50,000

Project Title: Community Work Incentive Coordinator (CWIC) Training and Staffing Costs

Scope:

This project proposes to use MHBG funds to cover Staff training costs for community behavioral health agencies to become Community Work Incentive Coordinators. Nothing provides 'hope' more than believing that people can work but addressing an individual's concerns about how working affects their governmental benefits is key to implementing the evidence-based practice model called Individual Placement and Support. Benefits counseling is one of the core principles of providing this EBP model.

Washington State's Foundational Community Supports (FCS) supported employment providers serve individuals using the Evidence Based Practice of Individual Placement and Support, the program developed and managed by Westat Rockville Institute. Washington state legislature mandated the use of evidence based or promising practices when Foundational Community Support (FCS) was approved. The intent is for the service to be statewide and in order to positively impact sustainability, services should be provided to fidelity in order to achieve the greatest outcomes. An important element of the principles of Individual Placement and Support is the education of job seekers of how income may impact federal and state benefits and entitlements. There is currently not the bandwidth in Washington's State to provide work incentive education and planning to enroll individuals in the Foundational Community Support system. The proposal is to send Foundational Community Support (FCS) agency staff from agencies to enroll in webinars to learn the foundational knowledge of Social Security work incentives, and to secure certification training for select agency staff at behavioral health organizations in Western and Eastern Washington State. This initiative will greatly increase the number of benefit practitioners to education and support job seekers in the transition to competitive employment, attain self-sufficiency while decreasing reliance on public entitlement programs. The Institute on Employment and Disability in Cornell University's Industrial and Labor Relations School training also has a credentialing option that provides a pathway to be recognized as an accredited work incentive planner. Work incentives pave the way to work and financial independence for recipients of public benefits. This training will provide essential insight into how the complex mix of work incentives, critically needed benefits, and earnings can be explained to an individual with a disability to encourage both work and financial independence.

There is a critical need for the training of benefit education planners in Washington State. The Foundational Community Support (FCS) program has 162 providers with 458 service location, with an enrollment of over 3,000 individuals. the availability of agency staff with foundational knowledge and access to certified benefit planners is crucial to provide support to enrolled participants and learn how earned income can impact entitlement benefits. These training opportunities will provide staff essential tools to assist job seekers to reach their individual goal of self-sufficiency. The implementation and practices of the Individual Placement Support (IPS) supported employment model are expanding in Washington State, and the critical need to adequately prepare agency staff of benefit planning curriculum is essential for overall long-term success. The certification training through the Institute on Employment and Disability in Cornell University's Industrial and Labor Relations School will prepare agency staff to support enrolled participants to develop a clear, comprehensive, and actionable report of an individual's financial situation and how to maximize self-sufficiency trends. There is not currently a more viable way to increase skills of agency staff and to increase the numbers of certified benefit planners.

Addressing State Needs and Gaps, Including Gaps in Equity:

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a way out of poverty and prevent entry into the disability system. The Individual Placement Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trails that demonstrated implementing Individual Placement Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive employment as compared to individuals not receiving Individual Placement Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

The Foundational Community Support Program is built upon evidenced based practices of SAMHSA and the Westat Rockville Institute to implement supported employment practices that are effective. The principles of these evidence-based practices (EBP) encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. The struggles of poverty and self-sufficiency negatively impact communities of people of color disproportionately. The implementation of based practices accelerates the positive impact on social determinants of health in urban and rural communities. Services are provided are inclusive of all who need them and targeted to individuals with a wide range of disabilities.

Project #: BGCE-RSS10

Project Title: Intentional Peer Support Training

Proposed Budget: \$150,000

*Additional \$150,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

These funds will be used to train Certified Peer Counselors in Intentional Peer Support. These trainings will be provided either in person or in a virtual format depending on physical distancing requirements. Priority for these training will be Certified Peer Counselors (CPCs) who work on the following teams Peer Bridgers, Housing and Recovery through Peer Services (HARPS), Forensic Housing and Recovery through Peer Services (HARPS), Projects for Assistance in Transition from Homelessness (PATH), Forensic Projects for Assistance in Transition from Homelessness (PATH), Peer Pathfinders, and Foundational Community

Support (FCS) teams. The training will be opened up to additional Certified Peer Counselors (CPCs) when space is available. This funding will also be used to provide travel supports for participants.

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors (CPCs) are effective in increasing recovery outcomes in mental health and Substance Use Disorder. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (EDI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS12

Proposed Budget: \$1,120,000

Project Title: Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disorder (SMI/SED).

Scope:

Proposed funds will add one peer counselor to each of the current Projects for Assistance in Transition from Homelessness (PATH). Project for Assistance in Transition from Homelessness (PATH) programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency will be required to hire and onboard a new peer counselor to expand outreach and engagement services for individuals with a serious mental illness (SMI) and homeless or at risk of homelessness. Projects will work closely with BHASO's, Managed Care Organization's (MCO's) and Crisis stabilization centers to create a referral flow and coordination of services.

The proposed expansion of adding one additional Projects for Assistance in Transition from Homelessness (PATH) peer counselor to each of the Projects for Assistance in Transition from Homelessness (PATH) teams will allow agencies to expand needed outreach and engagement efforts. The proposed funds will enhance the quality of program delivery and engagement and expand critical crisis resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

The intention of Homeless outreach services is to reach individuals who are not currently engaged in treatment, services and who are potentially unable to navigate the system. The ability to have one additional peer outreach team member will allow these programs to broaden the current outreach and engage services to a primary focus of crises response.

Projects for Assistance in Transition from Homelessness (PATH) teams currently serve individuals experiencing homelessness and mental illness and BIPOC communities. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: BGCE-RSS13

Project Title: Creating a Behavioral Health Housing Action Plan

Proposed Budget: \$15,000

*Additional \$15,000 SABG

Scope:

In 2007, the Mental Health State Transformation Initiative generated a Housing Action Plan. The Housing Action Plan conducted an inventory of affordable housing for people with serious mental illness, set a philosophical approach for Housing First principles and identified action steps to improve affordable housing. This proposal seeks to update the Housing Action Plan to include people with substance use disorders.

Washington is experiencing a significant housing crisis. Individuals with behavioral health conditions experience homelessness at a significant rate. The development of a housing action plan will create a north star for the behavioral health system to pursue partnerships to create and develop affordable housing.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will identify and analyze the needs and gaps for affordable housing for the behavioral health population. It will develop an action plan to meet the affordable housing needs of individuals with both mental health and substance use disorders.

The Behavioral Health Affordable Housing Action plan will analyze the impacts of homelessness on the BIPOC population. According to Research and Data Analysis, individuals experiencing homelessness are more likely to be African American or Alaska Native/American Indians (Ford-Shah, M., 2012)

Project #: BGCE-RSS14

Project Title: Creating a Housing Inventory/Estimator/Calculator

Proposed Budget: \$150,000

*Additional \$150,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Prison and jail re-entry and enhanced discharge from inpatient settings in order to reduce risks of COVID-19 transmission.

Scope:

The Research and Data Analysis Division (RDA) within the Department of Social and Health Services (DSHS) completed a series of reports in 2012 examining the housing status of individuals following their exit from institutional or out-of-home care settings. More than one-quarter of all five study populations (individuals leaving Substance Use Treatment Facilities; State Department of Corrections Facilities; Foster Care; State Mental Hospitals and Juvenile Rehabilitation Facilities) experienced homelessness at some point over a 12-month follow-up period. This project will create an online searchable tool based on various scenarios to connect individuals with behavioral health conditions to housing. Based on a current algorithm currently housed in the Pathways to Employment Site, Research and Data Analysis will create a housing version for the Pathways to Housing site.

This searchable tool that will be housed on the Research and Data Analysis Pathways to Housing site will be used to help address the fact that almost 50 percent of Individuals leaving residential substance use treatment facilities became homeless within the year of discharge. Individuals exiting prison, foster care, State Mental Hospitals, and Juvenile Rehabilitation facilities were more likely to experience homelessness but as likely to obtain to permanent housing when they received housing assistance. Across the five study populations, the proportion of individuals in need of housing who received Homeless Management Information System (HIMS)-recorded assistance was highest for youth aging out of foster care (at 35 percent). Even though this report is dated, it is believed these relate to the population we intend to start with: individuals with behavioral health issues still exist and may even be more exacerbated with the COVID pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will provide timely information for individuals with behavioral health conditions to access housing services and resources.

The searchable housing tool will ensure individuals with Behavioral Health conditions and part of the BIPOC population will have access to housing services and resources.

Project #: BGCE-RSS15

Project Title: Peer Dashboard

Proposed Budget: \$100,000

*Additional \$100,000 SABG

Scope:

This funding would be used to create a Dashboard for the Peer Support Program. This would enable the team to see data pulled from the Peer Support database on an easily accessible format. There is increased focus on the peer support program to meet the growing workforce needs. This dashboard would allow the Health Care Authority to have immediate access to data for updates to lawmakers and stakeholders. Without the dashboard the Peer Support Team and leadership would not have easily accessible data about the Peer Support Program.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is a Behavioral Health workforce shortage in Washington and peer services are a growing workforce that can help to meet the Behavioral Health needs of our communities. The dashboard will allow the Division of Behavioral Health and Recovery easy access to data that could direct the Peer Support Program where to focus trainings where gaps are identified to increase the Certified Peer Counselor (CPC) workforce and the diversity of the Certified Peer Counselor workforce.

Programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS17

Proposed Budget: \$15,000

*Additional \$15,000 SABG

Project Title: White Paper/Toolkits/Medicaid Academy for Peer-Run Peer-Operated Agencies

Scope:

This funding would be used to create a white paper to explore strategies for peer run/peer operated agencies to become licensed community behavioral health agencies so that they will be able to bill Medicaid for peer services.

This would provide technical assistance for clubhouse and consumer run organizations to become licensed providers and bill Medicaid for peer services. This will increase recovery support services to a larger portion of the state. Washington State supports several clubhouse programs using general fund dollars and SB 5328 is proposing that the state go farther in helping clubhouses gain access to Medicaid funds. This project aligns with the bill to assist those organizations to bill Medicaid.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently a shortage of behavioral health workers across Washington State. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. This would allow additional agencies to become licensed to provide peer services increasing the availability of Mental Health and Substance Use Disorder (SUD) peer services to a larger population. If unfunded, this technical assistance will not be available in the state and could delay agencies in getting licensed to provided peer services.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS18

Proposed Budget: \$50,000

*Additional \$50,000 SABG

Project Title: Foundational Community Support (FCS) – Converting Current Training to Online Training Modules

Scope:

Foundational Community Supports (FCS) provides supported employment and supportive housing services across the state of Washington with over 160 agencies contracted to provide Foundational Community Support (FCS) services. The Division of Behavioral Health and Recovery (DBHR) has four full time trainers who provide technical assistance to Foundational Community Support (FCS) providers. The growth of Foundational Community Support (FCS) has increased the need for technical assistance/training and the Division of Behavioral Health and Recovery (DBHR) would like to convert some of the "stock" training that it provides to all new Foundational Community Support (FCS) providers to a virtual format. Creating online training modules of stock trainings currently provided in person will free up time for Foundational Community Support (FCS) trainers to provide more individualized, targeted, and intense technical assistance.

This project is critical to maintaining and improving the quality of services provided by Foundational Community Support (FCS) providers. Focused, targeted, and high-level training ensures consistency and adherence to the evidence-based modules that Foundational Community Support uses. Currently, the Division of Behavioral Health and Recovery Foundational Community Support trainers are spending

much of their time delivering stock training to providers as they onboard new staff. This type of training could easily be provided in a virtual recorded format that would free up the Foundational Community Support (FCS) trainers time to provide more advanced targeted technical assistance to providers. Freeing up the Foundational Community Support (FCS) trainers time to focus on more targeted and nuanced technical assistance allows us to grow the quality of the Foundational Community Support program.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal justice interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a way out of poverty and prevent entry into the disability system. The Individual Placement Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trails that demonstrated implementing Individual Placement Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive employment as compared to individuals not receiving Individual Placement Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

Foundational Community Supports utilizes the evidence-based practices of SAMSHA's Permanent Supportive Housing and Westat's individual placement and support. The principles of these evidence-based practices encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. These services also value and approach participants with equity, respect as well as cultural humility with the hope of promising outcomes.

Project #: BGCE-RSS19

Proposed Budget: \$500,000
*Additional \$500,000 SABG

Project Title: Cover Foundational Community Support (FCS) Services in Institution of Mental Disease (IMD) When Medicaid is Suspended

Scope:

The Division of Behavioral Health and Recovery proposes to utilize block grant funds to cover Foundational Community Support services for people transitioning out of Institution of Mental Disease (IMD) settings if the Medicaid isn't retroactively reconnected. The Foundational Community Support (FCS) program assists eligible individuals with complex health needs obtain and maintain stable housing and can provide Foundational Community Support services within short-term Institution of Mental Disease (IMD) settings with housing assessments and begin the housing acquisition process prior to discharge. These newly added services to Foundational Community Support will include coaching, advocacy, information and referral, linking and coordinating, and ongoing supports that they may not otherwise have access to.

The program offers an array of transition/pre-tenancy and tenancy-sustaining supports that have been effective in improving housing stability, health and employment outcomes for high need Medicaid beneficiaries. linking and coordinating, and ongoing supports that they may not otherwise have access to. Many of these individuals have complex health profiles and face multiple housing related barriers to effectively engaging with health care systems and managing their own plan of care to achieve improved health and wellness. Foundational Community Support have reduced the frequent use of emergency department and inpatient care, addressed significant gaps in connections to care, addressed homelessness, and now can help to facilitate timely, successful transitions from institutional settings to integration in community placements. Anticipated Outcomes:

- Effectively target interventions to eligible individuals in residential treatment settings;
- Streamline and standardize transition and tenancy-sustaining services for individuals exiting residential treatment across agencies and systems;
- optimize and braid all available funding to fill gaps;
- reduce Substance Use Disorder/Opioid Use Disorder (SUD/OD) related deaths;
- improve Substance Use Disorder system capacity; and
- improve quality of care

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is no other mechanism to reimburse Foundational Community Support providers if the individuals Medicaid is not active at the time of authorization. The Health Care Authority has taken steps to attempt to mitigate this by providing Foundational Community Support providers access to Provider One to check Medicaid eligibility. This however is not a perfect solution and there are times when Foundational Community Support providers go unpaid.

The Foundational Community Support program is based on the evidence-based practices (EBP) of Permanent Supportive Housing (PSH) and Individual Placement and Support (IPS). The principles of these Evidence-Based Practices encompass equity and racial justice through the promotion of choice, flexible voluntary services, and access.

Project #: BGCE-RSS20

Project Title: Peer Wellness Coach Training

Proposed Budget: \$15,000

*Additional \$15,000 SABG

Scope:

These funds would be used to bring either Peggy Swarbricks Wellness coaching or Pat Deegan's Personal Medicine Coach certification training to Certified Peer Counselors. Pat Deegan's program can also bring a train the trainer to Washington so that we can training Certified Peer Counselors in Personal Medicine Coach training.

This project will provide continuing education to certified peer counselors in Washington State around. The intended outcome is to increase the knowledge of certified peer counselors to even more effectively support the peers they serve. Both programs focus on increased health outcomes. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors.

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors are effective in increasing recovery outcomes in mental health and Substance Use Disorder (SUD). Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors. This continued education will provide information to better support people in whole health as we are moving to a more integrated approach to who person care.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices, and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS22

Project Title: Training for Oxford Outreach Staff

Proposed Budget: \$20,000

*Additional \$20,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

DBHR currently funds 10 outreach staff that provide support to the 300+ Oxford houses in Washington State. Individuals with co-occurring SMI and SUD diagnosis are recipients of the mutual support received within an Oxford house. This proposal is to fund training for the 10 outreach staff to better

support the individuals with co-occurring serious mental illness and substance use disorders. Training topics include but not limited to de-escalation, mediation, grief counseling etc.

We would like to add funding for training Oxford House Outreach Workers. There have been too many deaths in the Oxford Houses since COVID-19 started due to isolation and the feelings of hopelessness which brings an increase in drug and fentanyl use and ultimately relapses and deaths. Therefore, there is a need for the 10 Oxford House Outreach Representatives to get trainings on de-escalation, grief and loss, relapse prevention, meditation, Dialectical Behavioral Therapy (DBT), and any other training that would benefit the Oxford House Representatives in helping the residents deal with their grief, losses and fears of relapse.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Oxford House Sober Recovery Homes fills a gap in the substance use disorder services continuum by establishing and maintaining self-run, self-supported peer-operated sober recovery homes. In adherence with United States Code, Title 42, Section §300X–25 Group Homes for Recovering Substance Abusers, the State Agency will utilize the Oxford House concept to increase sober recovery housing assistance opportunities for recovering individuals living together in a residential disciplined environment to maintain recovery without recurrence of use. This level of care includes the provision of a safe and affordable home, in a drug-free living situation to recovering individuals with the support of other peers in recovery, Contractor staff, and other supports and services in the community including mental health guidance from outreach representatives who are trained.

Adult men and women completing residential treatment or are currently in outpatient treatment for substance use disorder, as well as those enrolled in recovery support, and opioid treatment services, who need a place to live and can meet the requirements for being a resident of a Recovery House. People leaving prisons and jails, Oxford House has a strong re-entry program with Department of Corrections (DOC) and does not discriminate on anyone's culture, race, or mores. Recovery housing will also include populations with a reported history of opioid use disorder (OUD) and opioid use.

Project #: BGCE-RSS23

Project Title: Participant Engagement Kits for Youth – Mockingbird

Proposed Budget: \$35,000

*Additional \$35,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice example. This project would provide funds directly related to benefit participants in homeless outreach teams to assist individuals who are seriously mentally ill and not engaged in treatment. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

The Mockingbird Society creates, supports, and advocates for racially equitable, healthy environments that develop young people at risk of or experiencing foster care or homelessness. The Youth Advocates Ending Homelessness in Washington state report an alarming number of youth experience mental health, substance use disorders and health crisis. This includes advocates that report individuals who are experiencing medical issues that may or may not receive medical treatment. The inability to care for wounds will likely cause more server health issues or worse. Proposing funding for Mockingbird Outreach for Homeless Hygiene and wound care kits such as hand sanitizer, antiseptic, rubbing alcohol, hydrogen peroxide, ointment, band aids, gauze, and pain relievers could make the difference.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Mockingbird Society of Washington report Homeless youth lack access to medical care and often go without essential hygiene and wound care items which are not covered by Medicaid.

The Mockingbird Society creates, supports, and advocates for racially equitable, healthy environments that develop young people at risk of or experiencing foster care or homelessness.

Project #: BGCE-RSS24

Project Title: Peer Pathfinders Transition from Incarceration Pilot

Proposed Budget: \$790,000

*Additional \$790,000 SABG

Scope:

This funding will add a Certified Peer Counselor to up to five existing BH-ASO contracts for jail transition services. Adding a Certified Peer Counselor to existing jail transition services teams will increase the level of services being provided, by having a CPC connect with the individuals while they are still in jail and helping them with transition to the community. The certified peer counselor will work with individuals diagnosed with a serious mental illness, linking them to behavioral health services, including co-occurring treatment, Foundational Community Support (FCS), and other applicable services.

Multiple studies support the fact that Peer support services has significant impacts on quality of life, reducing substance use, and improving positive social supports. Studies have also identified common elements of peer support, suggesting possible processes that underlie effective peer support. Peer services include shared experiences, role modelling, and positive social support. All of which are suggested to be vital aspect of peer support and moderate positive life changes. By adding a certified peer counselor to existing Jail Transition services allows for access to these vital services for individuals with SMI and co-occurring health conditions, reducing likelihood for further court involvement. Impacts that are likely to occur if this project is not approved included recidivism because the individual was not provided the needed services during their jail transition.

Addressing State Needs and Gaps, Including Gaps in Equity:

People exiting jails are more likely to be successful when they are able to connect and engage in services in their communities upon release. Currently in some parts of the state jail transition services are only reaching jail populations a few times a month. By adding a Certified Peer Counselor to existing jail transition services, individuals who are in need of extra support in accessing community-based services can be offered the support of a peer. These certified peer counselors would focus on linking individuals

to behavioral health services, including co-occurring treatment, housing and employment, and community resources.

A disproportionate number of individuals of color are represented in our criminal court system and they experience greater barriers in accessing healthcare and community behavioral healthcare. This problem is greater amplified the further away you move from urban settings and locations in which more services are available. By adding the support of a Certified Peer Counselor to existing jail transition services, this will increase the likelihood of individuals being able to overcome some of these barriers.

Project #: BGCE-RSS25

Project Title: Add Co-Occurring Peer to F-HARPS

Proposed Budget: \$400,000

*Additional \$400,000 SABG

Scope:

These additional funds would allow the teams to hire another certified peer counselor for each Forensic HARPS team in the phase 1 regions. With this additional staff person, the teams would be able to increase caseload capacity. This position would also allow the Forensic HARPS teams to serve individuals diagnosed with serious mental illness or co-occurring.

This project is critical because it will increase the capacity of the teams to serve more eligible individuals through the Forensic HARPS program, an element of the Trueblood Settlement. Housing access, support, and short-term subsidies increase an individual's opportunity for recovery. Housing is a basic need that reduces the likelihood of recidivism in the criminal court system. If this funding is not approved, the Forensic HARPS teams will not be able to serve all those who are eligible and in need of this service.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Forensic HARPS teams have short-term housing subsidy dollars to assist participants in obtaining and maintaining housing. The amount of subsidy dollars allocated to each team is greater than what the current staffing model allows them to spend. With this additional staff person, the Forensic HARPS teams will be able to fully utilize the subsidy dollars allocated to them. Funding Forensic HARPS teams is cost effective because it diverts individuals with serious behavioral health conditions into receiving the services, they need instead of being arrested or hospitalized. Supportive housing reduces inpatient hospitalization, incarceration and engagement in outpatient treatment increases when individuals are successfully housed (RDA, FCS preliminary outcomes 2020).

Helping individuals obtain and maintain housing of their choice helps them be more successful in treatment. Forensic HARPS teams are trained in leveraging all community resources once an individual exits jail or an institutional setting, but the 'bridge subsidy' is still needed in order to assist individuals exit jail as quickly as possible.

A disproportionate number of individuals of color are represented in our criminal court system. Many of these individuals experience significant barriers in accessing safe and affordable housing. WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. People with trauma, a history of homelessness, and co-occurring disorders have an increased likelihood of being involved in the criminal

court system. Helping individuals find and maintain housing of their choice, and obtain wanted services, especially during an increased time of hardship such as COVID-19 is our states responsibility.

Project #: BGCE-RSS32

Project Title: Operationalizing Peer Bridger

Proposed Budget: \$25,000

*Additional \$25,000 SABG

Scope:

This funding will be used to create an Operationalizing Peer Support training for the peer Bridger program for jails, hospitals and Substance Use Disorder (SUD) treatment agencies. Operationalizing Peer Support trainings provide Technical Assistance (TA) to existing and new agencies who need support with their peer program or who want to implement peer services. This training would also be to provide technical assistance to the jails, hospitals and inpatient setting who will be collaborating with the peer Bridger program.

As we transition the peer Bridger from providing services at the state hospitals into community-based hospitals and inpatient settings, technical assistance will be beneficial in the transition for the agencies, hospitals, and the peer Bridger program. If not approved, there will be confusion about the peer Bridger program and how to effectively utilize the services resulting in people not receiving these recovery support services. This could increase recidivism into an inpatient setting.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently a shortage of behavioral health workers across Washington State. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. We are currently witnessing gaps in service since the 90/180-day beds went live last year. This needed TA would be able to provide the necessary support and education to effectively utilize the peer Bridger program increasing recovery supports in inpatient settings.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS33

Proposed Budget: \$100,000

Project Title: Create a Dashboard on Healthcare for Workers with Disabilities

Scope:

Washington's Healthcare for Workers with Disabilities is the Medicaid Buy-in Program. Nothing provides 'hope' more than believing that people can work but addressing an individual's concerns about how working affects their governmental benefits is key to implementing the evidence-based practice model called Individual Placement and Support. Benefits counseling is one of the core principles of providing this EBP model. Part of benefits counseling is to help individuals access work incentives such as the Medicaid Buy-in Program to ensure working doesn't have adverse effects to their receipt of services or medications. This project would promote this untapped work incentive program/Medicaid Buy-in program through the creation of a marketing campaign and public dashboard on the utilization of the benefit. According to Research and Data Analysis in the 2nd quarter of 2020, only 12 percent of disabled individuals with a serious mental health issue were employed in Washington State. (10,631/88,381). There are currently 1606 individuals in WA on HWD.

The Apple Health for Workers with Disabilities (HWD) program recognizes the employment potential of people with disabilities and represents Washington State's response to the landmark "Ticket to Work" legislation passed by Congress in 1999. Healthcare for Workers with Disabilities (HWD) is an underutilized program within the state of Washington. This is a critical program to provide low-cost healthcare for people with disabilities, enabling people with disabilities to no longer have to choose between taking a job and having health care, and therefore work to their full potential. Marketing needs to include the message that self-sufficiency is attainable. There is a need to communicate measurements of number of individuals using the service as a part of marketing the program. This proposal is to develop a public facing dashboard as a part of marketing. There will be collaboration between the Health Care Authority departments that have Healthcare for Workers with Disabilities (HWD) as part of the service provided, with the communications department, and with Research and Data Analysis in order to come up with an attractive and fully functioning site that provides current and accurate data.

The benefit to the government is shifting individuals off of benefits and having them add to tax revenue. Under Healthcare for Workers with Disabilities, people with disabilities can earn more money and purchase health care coverage for an amount based on a sliding income scale.

Healthcare for Workers with Disabilities benefits include:

- Medicaid benefit package
- Access to long term services and supports, if functional requirements are met
- Greater personal and financial independence
- Members can earn and save more without the risk of losing their healthcare coverage

If not approved, people with disabilities have less encouragement to work and continue to live below the poverty level while remaining on public benefits. It disproportionately negatively impacts ethnic minorities.

Addressing State Needs and Gaps, Including Gaps in Equity:

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery, but many avoid seeking work due to fear of losing benefits. Employment has many positive impacts on the mental health and wellbeing of individuals with

psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Results from regressions on earnings suggest that Healthcare for Workers with Disabilities (HWD) participants with prior Medicaid coverage earn substantially more than non-participants in the year following enrollment. On average, they earn roughly \$2,000 more than their contemporary peers in the following year and \$2,500 more than a historical comparison group. Healthcare for Workers with Disabilities (HWD) Participants historically rely less on Basic Food benefits.

Healthcare for Workers with Disabilities (HWD) will create and sustain a culture of respect, caring and inclusion through employment. Programs that focus on employment enhance the value and respect garnered by the individual and help them to sustain their culture in the community. It empowers them to become positive role models. Services provided are inclusive of all who need them and targeted to individuals with a range of disabilities that have become successfully employed. Outreach will address the foregoing population.

Project #: BGCE-RSS35

Project Title: Implicit Biased Training for Landlords

Proposed Budget: \$10,000

*Additional \$10,000 SABG

Scope:

This project would create a training series for landlords on Implicit Bias. Implicit bias describes our attitudes towards people or associates stereotypes with them without our conscious knowledge. Implicit Bias trainings are designed to exposed to people to their biases and provide tools to adjust automatic patterns of thinking and ultimate eliminate discriminatory behaviors.

The Division of Behavioral Health and Recovery would work in partnership with the Department of Commerce's Landlord Mitigation Project to provide training to landlords who often rent to individuals with behavioral health conditions. Training would focus on addressing and identifying implicit biases and how this could be unintendedly affecting their decision on who to rent to.

This project is important because Washington State has a serious deficit of safe and affordable housing. This means that rentals are extremely scarce, and landlords could unintendedly discriminate against people of color and people with behavioral health conditions. The anticipated outcome of this project is to help landlords identify and then address their implicit biases.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal court interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

A disproportionate number of individuals of color experience housing instability. Many of these individuals experience significant barriers in accessing safe and affordable housing. WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. People with trauma, a history of homelessness, and co-occurring disorders have an increased likelihood of being involved in the criminal court system. This training will educate landlords on how their implicit bias might limit who they choose to rent to.

Project #: BGCE-RSS36

Proposed Budget: \$500,000

Project Title: Funding for SSI/SSDI, Outreach, Access, and Recovery (SOAR) Leads

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance.

Scope:

SSI/SSDI Outreach Access and Recovery (SOAR) is a proven effective model to increase access to governmental benefits. This project would create a SOAR Lead Position in multiple regions/counties (scalable). SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads hold local steering committee meetings, lead SSI/SSDI, Outreach, Access and Recovery (SOAR) online course training cohorts and conduct half-day SSI/SSDI, Outreach, Access and Recovery (SOAR) online course review sessions. SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads will also be mentoring individuals who complete the SSI/SSDI, Outreach, Access and Recovery (SOAR) online course and reporting on outcomes.

This will provide increased access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a serious mental illness. Access to these benefits will help individuals stabilize their housing and health.

Addressing State Needs and Gaps, Including Gaps in Equity:

Many unhoused individuals qualify for disability benefits but have a difficult time getting through the application process. With an SSI/SSDI, Outreach, Access Recovery (SOAR) Representative assisting with the application process, individuals are approved more often and more quickly. Most landlords require some kind of monthly income, this will help provide that and allow more individuals to obtain housing.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity

through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS41

Project Title: Enhance Mobile Crisis Teams with CPCs

Proposed Budget: \$1,909,000

Scope:

HCA will build upon the Transformation Transfer Initiative (TTI) crisis services continuing education curriculum for Certified Peer Counselors by piloting enhancements to mobile crisis teams by adding Certified Peer Counselors to existing teams. Funds will be issued to BH-ASOs to expand Mobile Crisis Response services serving those diagnosed with SMI/SED.

This project will provide enhance mobile crisis services by adding certified peer counselors in Washington State. The intended outcome is to increase the engagement and outreach of MCR teams to include certified peer counselors to even more effectively support the peers they serve in crisis settings.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. Expanding mobile crisis services to include Certified Peer Counselors will better support people as Washington expands peer services in crisis settings.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote DEI and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Tribal Projects Detail

Project #: BGCE-TRB3

Project Title: Funding to Tribes and Urban Indian Health Organizations

Proposed Budget: \$861,000

*Additional \$1,270,794 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Operation of an “access line,” “crisis phone line,” or “warm lines” to address any

mental health issues for individuals.

- Training of staff and equipment that supports enhanced mental health crisis response and services.
- Mental Health Awareness training for first responders and others.
- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).
- Prison and jail re-entry and enhanced discharge from inpatient settings in order to reduce risks of COVID-19 transmission.
- COVID-19 related expenses for those with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED), including testing and administering COVID vaccines, COVID awareness education, and purchase of Personal Protective Equipment (PPE)

Scope:

The Health Care Authority will provide contracts to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver needed mental health services to adults and youth with SMI/SED to prevent, prepare for and respond to behavioral health gaps due to COVID within their Tribal communities. Tribes would submit a plan to implement recommended services as outlined in the NOA and allowed within the Mental Health Block Grant (MHBG) regulations. Additional Funds to Tribes \$40,993 SABG per Tribe and \$27,778 MHBG per Tribe, totaling \$68,771 for each Tribe.

This project is important because American Indian/Alaskan Native (AI/AN) and Tribal communities have been greatly affected by the COVID pandemic and the various Tribal and State Stay at Home Orders. Tribes are navigating how to operate Behavioral Health program in a virtual and semi/virtual environment. Due to the pandemic, Tribes are stating that the individuals in their communities are struggling with social isolation and a lack of treatment services due to the pandemic. There has also been limited cultural activities available for Tribal communities due to the pandemic. The historic annual Canoe Journey was canceled two years in a row with very limited ability to implement cultural programs across all Tribal communities.

Addressing State Needs and Gaps, Including Gaps in Equity:

Department of Health (DOH) reported that overdose rates have gone up over 154% during the first 6 months of the pandemic and is the highest of other communities by race/ethnicity. The statewide increase overall is 30%. The Health Care Authority needs to continue to provide resources to Tribal communities to address those diagnosed with SMI or SED for American Indian/Alaskan Native (AI/AN) in WA. Providing direct funding to Tribes and Urban Indian Health Programs (UIHPs) also honors our government-to-government relationships by partnering with Tribes to serve American Indian/Alaskan Native WA State residents.

This project directly supports Diversity, Equity and Inclusion (DEI) by providing needed services to the American Indian/Alaskan Native (AI/AN) population in providing culturally appropriate services. This also honors our unique Government-to-Government (G2G) relationships with Tribal governments and our partnership with Urban Indian Health Programs (UIHPs).

Crisis Services:

Tribes and Urban Indian Health Programs (UIHPs) may provide crisis services with these funds. The Health Care Authority will pass down National Guidelines to Tribes to provide guidance on best practices for crisis services.

Project #: BGCE-TRB4

Project Title: Traditional Healing Pilot Project

Proposed Budget: \$100,000

*Additional \$100,000 SABG

Scope:

The Health Care Authority will contract with the Seattle Indian Health Board (SIHB) to (1) document best practices (including practice and administrative tools) for an Indian Health Care Provider (IHCP) to offer traditional healing/traditional Indian medicine (TIM) services, and (2) analyze the health outcomes and potential cost savings from offering Traditional Indian Medicine (TIM) services. TIM can serve individuals with SMI/SED and substances use disorder, alongside Western based strategies for the prevention, treatment, and recovery of SMI/SED/SUD. TIM can also help with SMI/SED/SUD prevention. The services may include storytelling, talking circles, drumming, sweat lodge, prayers, blessings (such as cleansing and smudging), etc. TIM services are provided by a community-verified practitioner of TIM. Please note that this grant will not pay for actual TIM services. The Seattle Indian Health Board (SIHB) deliver the following to the Health Care Authority:

1. Recommendations for billing, coding and reimbursement models for Traditional Indian Medicine (TIM) services.
2. Analysis, recommendations, and examples of charting for Traditional Indian Medicine (TIM) services and incorporation of charting into an Electronic Health Record (EHR).
3. Recommendations and analysis on best practices for incorporating Traditional Indian Medicine (TIM) practitioners into integrated care teams.
4. Recommendation and analysis for privileging and credentialing standards of Traditional Indian Medicine (TIM) practitioners and apprentices.
5. Evaluation and analysis of the health outcomes for individuals and populations receiving the Traditional Indian Medicine (TIM) services. Measures could include:
 - Number of services completed;
 - Impacts on health outcomes;
 - Policy analysis;
 - Estimated costs of encounters;
 - Cost benefit analysis;
 - Comparison of the population that receives Traditional Indian Medicine (TIM) and the population that does not;
 - Comparison of patient's perception of their health pre-Traditional Indian Medicine (TIM) services and post-Traditional Indian Medicine (TIM) services, etc.

These items will be submitted as separate reports and guidance documents that will be available for the Health Care Authority, federal partners and other Indian Health Care Providers and Tribes in providing technical assistance on integrating Traditional Indian Medicine (TIM) into health programs with a focus on the treatment and recovery of Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

The Washington Indian Health Care Improvement Act, passed by the state legislature in 2019, had three main goals:

1. Provide resources to ensure the highest possible health status of American Indians/Alaska Natives (AI/AN) in Washington;
2. Raise the health status of American Indian/Alaskan Native (AI/AN); and
3. Ensure tribal self-determination in the areas of health care services.

One recommendation coming out of the Act was the expansion of traditional Indian medicine (TIM). This project helps the Health Care Authority to honor this key recommendation. Traditional Indian Medicine (TIM) services provide unparalleled support for American Indian/Alaskan Natives individuals struggling with severe mental illness or severe emotional disturbances and Western medicine has proven to not be appropriate for treatment and recovery supports for these American Indian/Alaskan Native (AI/AN) individuals. The anticipated outcome is documentation of positive health outcomes for individuals receiving Traditional Indian Medicine (TIM) and guidance to other Indian Health Care Providers (IHCP) on how to incorporate Traditional Indian Medicine (TIM). If not approved, we will continue to have a lack of literature available to demonstrate positive health outcomes or cost saving of these services for American Indian/Alaskan Native (AI/AN) and therefore, continue to struggle in finding sustainable funding.

Addressing State Needs and Gaps, Including Gaps in Equity:

The WA State Department of Health has found that American Indian/Alaska Native (AI/AN) overdose fatality rates have gone up 154% during the COVID pandemic. There is a known gap in the provision of culturally appropriate services for American Indian/Alaskan Natives (AI/AN) in the state of Washington and at a national level. Tribes and Indian Health Care Providers (IHCPs) are the experts in providing culturally appropriate services; however, Traditional Indian Medicine (TIM) does not have a sustainable funding mechanism. There are many evidence-based practices (EBP) available for Mental Health services; however, there are limited studies with American Indian/Alaskan Natives (AI/AN). Tribes and Indian Health Care Providers (IHCPs) find that implementing Evidence-Based Programs do not always work for American Indian/Alaskan Native (AI/AN) individuals and Tribal communities. This project will seek to develop evidence related to the efficacy of Traditional Indian Medicine (TIM) services for American Indian/Alaskan Natives (AI/AN) suffering from severe emotional disturbance or severe mental illness.

This project directly addresses Diversity, Equity and Inclusion (DEI) principles by providing support for Traditional Indian Medicine (TIM) and integration with clinically based health care. For decades, the response to Traditional Indian Medicine (TIM) is there is a lack of clinical data associating Traditional Indian Medicine (TIM) with better health outcomes. This pilot project will provide guidance around integration of Traditional Indian Medicine (TIM) and clinically based primary care and preliminary data to build the case for Traditional Indian Medicine (TIM). The intent is to provide foundational research and evidence that will support a request for sustainable Medicaid reimbursement for Traditional Indian Medicine (TIM).

Crisis Set-Aside Projects Detail

Project #: BGCE-ASO2

Proposed Budget: \$1,346,000

Project Title: Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding for Crisis Services

Scope:

Funding directed to the Behavioral Health Administrative Service Organizations (BH-ASO's) will support their respective provider networks enhancing the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. Funding will be used to enhance existing Crisis Services provided 24 hours a day, seven days a week including crisis call line, evaluation and treatment services for Individual's ineligible for Medicaid, including involuntary inpatient services, voluntary inpatient services, crisis stabilization services, Employment and Training (E&T) services, and services for the priority populations defined per Contract. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retention issues that have increased throughout the behavioral health delivery system during the pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that

policies and procedures have had different negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation. Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based mental health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health and substance use crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments; and strategies to reduce the fragmentation of mental health care.

Washington

COVID-19 Supplemental Funding Plan for FY21

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

Center for Mental Health Services
Division of State and Community Systems Development

Mental Health Block Grant COVID Supplemental Funding Plan

WA State Summary

The COVID-19 pandemic has had a significant impact on people with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) in Washington State. During the first half of 2019, 8.2% of adults over 18 years of age had symptoms of anxiety disorder and 6.6% had symptoms of depressive disorder. By comparison, in the most recent Household Pulse Survey from the Centers for Disease Control examining trends from February 17, 2021 to March 1, 2021, this prevalence quadrupled to 33.4% for anxiety and 27.7% for depression (in Washington state, rates were slightly higher with 34.2% for anxiety, 14th highest of the 50 states, and 27.8% for depression, 23rd highest of the 50 states). The age group with the highest prevalence rates nationally is 18–29-year-olds (47.2% reporting anxiety, and 42.2% reporting depression). The devastating impacts of the COVID-19 pandemic have clearly impacted young adults' mental health and substance use (a population already at high risk).

As the state and nation emerge from early Phases of the pandemic, the resulting impacts of the last year are a salient concern. People face potentially new obstacles such as continued mental health issues, overcoming the potential disruptions in school, work, and finances, and re-engaging in social life with continued recommendations from the CDC and local health departments (e.g., mask mandates). This is a critical time to address potential harms and to encourage engagement in both adaptive coping behaviors and unique strategies of social engagement within current public health guidelines to reduce high-risk substance use and worsening mental health symptoms, in both adults and youth.

HCA's Division of Behavioral Health and Recovery has reviewed the *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* and allocated a percentage of the total potential COVID-19 relief supplemental funding to address principles focused on recovery needs, support for the behavioral health workforce, particularly of Peers and Recovery Support Peers, and trauma-informed treatment services. The budget summary, on the following pages, provides the detailed amounts allocated across the continuum of behavioral health services through a wide variety of projects, treatment funds provided through our Behavioral Health Administrative Service Organizations (BH-ASO's) and Tribes. WA Health Care Authority, with input from partners, including the Behavioral Health Advisory Council, respectfully submits the proposals you will find in the pages to follow.

As part of our effort to seek stakeholder input, the Behavioral Health Advisory Council co-hosted a meeting with the Health Care Authority to invite input from various partners and representatives from across the state's behavioral health system (from Peers to school districts, as well as counties, managed care organizations and others). Input on the proposals was received at the end of the event, which helped to inform the direction, as well as solidify the allocations to each section and confirm what flexibilities to seek within the application for these COVID-19 relief supplemental funds. In addition to waiver flexibilities, the Health Care Authority may also require some flexibility to move allocations from one proposal, to another, within those in this application, in the event a particular proposal is particularly successful and requires funding allocation from another proposal which may not require the entire allocation presented in this application.

Within the budget summary below, you will find the proposed project titles, a brief description and number for each project under the sections of First Episode Psychosis, Treatment, Recovery Support Services and Crisis Services. In the pages that follow, a longer project narrative will include the project title, budgeted amount, a description, or scope of work summary, as well as a narrative of how the project addresses state needs and gaps, especially gaps in equity.

WA is grateful to SAMHSA for the opportunity to apply for the COVID-19 relief supplemental funds, as this has been an unprecedented year of extreme stressors to the most vulnerable among us, and the funding will undoubtedly support those persons at greatest risk, as well as those who seek support in treatment and ongoing recovery.

Project List and Budget Table

FEP Set-Aside			
Project #	Project Title	Project Description	Proposed Budget
Project #: BGCE-CYF7	Rural and AI/AN Pilot Project for FEP	Develop and adapt evidence based coordinated specialty care programs for FEP to meet the needs of rural, frontier and AI/AN communities.	\$ 2,307,000
Total FEP Set-Aside			\$ 2,307,000
Treatment			
Children, Youth and Family Treatment Funding			
Project #	Project Title	Project Description	Proposed Budget
Project #: BGCE-CYF2	Developing Wraparound and Intensive Services (WISe) Workforce Support	Developing Wraparound and Intensive Service (WISe) workforce to support youth with Intellectual Disabilities/Developmental Disabilities (including Autism Spectrum Disorder (ASD)).	\$ 200,000
Project #: BGCE-CYF5	Trauma Focused Cognitive Behavioral Therapy Training	Trauma Focused Cognitive Behavioral Therapy (CBT) Training for clinicians serving children and youth returning to school as part of the triage process post screening.	\$ 376,671
Adult Treatment Funding			

Project #: BGCE- MHA1	Cognitive Behavioral Therapy for Psychosis	Expansion of current contract to deliver Cognitive Behavioral Therapy for Psychosis to a cohort of clinicians who are serving people on 90/180 involuntary civil commitment orders.	\$ 130,000
Project #: BGCE- MHA2	Trauma Informed Care for Designated Crisis Responders	Modify curriculum of Trauma Informed Care training specifically for Designated Crisis Responders to incorporate the skills into their practice.	\$ 50,000
Project #: BGCE- MHA3	Mental Health Specialist Training	Develop a curriculum for a 100-hour course for Mental Health (MH) professionals to secure credentials to become an Older Adult Mental Health Specialist, Intellectual Disabilities /Developmental Disabilities (ID/DD) Mental Health Specialist, and Ethnic Minority Mental Health Specialist.	\$ 396,329
BH-ASO Treatment Funding			
Project #: BGCE- ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding	The community mental health services provided include but are not limited to outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, residents of the service areas who have been discharged from inpatient treatment at a mental health facility, day treatment or other partial hospitalization services, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, or ready for discharge from inpatient psychiatric care, and individuals residing in rural areas.	\$ 6,150,372
Total Treatment			\$ 7,303,372
Recovery Support Services			
Project #	Project Title	Project Description	Proposed Budget

Project #: BGCE- RSS1	Participant Support Funds- Housing and Recovery through Peer Services (HARPS) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	50,000
Project #: BGCE- RSS2	Participant Support Funds- Projects for Assistance in Transition from Homelessness (PATH) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	140,000
Project #: BGCE- RSS3	Participant support Funds - Peer Bridger	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	100,000
Project #: BGCE- RSS7	Certified Peer Counselor (CPC) Online Continuing Education Bank	Create online Certified Peer Counselor (CPC) continuing education trainings.	\$	50,000
Project #: BGCE- RSS8	Foundational Community Support Supported Housing/Supported Employment (SH/SE) 'fidelity reviewer certification'	Creating a Supported Housing (SH) fidelity certification development/Individual Placement and Support (IPS) certification through Westat.	\$	50,000
Project #: BGCE- RSS9	Community Work Incentive Coordinator (CWIC) training and staffing costs for a provider to attend the training	Training for Foundational Community Support service providers to become Community Work Incentive Coordinator (CWIC) trained - https://vcu-ntdc.org/training/introductory/introindex.cfm	\$	50,000
Project #: BGCE- RSS10	Intentional Peer Support Training	Train Certified Peer Counselors in Intentional Peer Support.	\$	150,000
Project #: BGCE- RSS12	Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams	Targeted peer outreach on Project for Assistance in Transition from Homelessness (PATH) teams focusing on a by-name list of individuals who have had multiple contacts with crisis system.	\$	1,120,000

Project #: BGCE-RSS13	Creating a Behavioral Health (BH) Housing Action plan	Inventory of all the housing needs of the Behavioral Health (BH) population.	\$	15,000
Project #: BGCE-RSS14	Creating a housing inventory/estimator/calculator	Provide timely information for individuals with behavioral health conditions to access housing services and resources.	\$	150,000
Project #: BGCE-RSS15	Peer Dashboard	Extract data out of the peer credential data system to have a dashboard.	\$	100,000
Project #: BGCE-RSS17	White paper/Toolkits/Medicaid Academy for Peer Run-Peer Operated Agencies	Creating a white paper on Community Behavioral Health Associate (CBHA) Lite licensing.	\$	15,000
Project #: BGCE-RSS18	Foundational Community Support - Converting Current Training to Online Training Modules	Convert Foundational Community Support training to online training modules.	\$	50,000
Project #: BGCE-RSS19	Cover Foundational Community Support Services in Institution for Mental Disease (IMD) when Medicaid is Suspended	Utilize block grant funds that would cover Foundational Community Support services for people transitioning out of Institution for Mental Disease (IMD) settings if Medicaid does not get retroactively reconnected.	\$	500,000
Project #: BGCE-RSS20	Peer Wellness Coach Training	Peer Wellness Coach continuing education curriculum developed.	\$	15,000
Project #: BGCE-RSS22	Training for Oxford Outreach Staff	De-escalation, mediation, basic grief counseling training for 10 Oxford outreach staff.	\$	20,000
Project #: BGCE-RSS23	Participant Engagement Kits for Youth - Mockingbird	Mental Health Block Grant (MHBG) & Substance Abuse Block Grant (SABG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$	35,000

BGCE-RSS24	Peer Pathfinders Transition from Incarceration Pilot	Enhance jail transition programs with SUD peers services to individuals who upon release will be homeless. SUD Peer Services begin prior to release to establish relationship and upon release to support the transition to needed services.	\$ 790,000
BGCE-RSS25	Add Co-Occurring Peer to Forensic-Housing Housing and Recovery through Peer (F-HARPS) Services	Add 1 peer to each of the four Forensic-Housing Housing and Recovery through Peer Services (F-HARPS) in Phase I regions.	\$ 400,000
Project #: BGCE-RSS32	Operationalizing Peer Bridger	Create an operationalizing Peer Bridger program for hospitals, Substance Use Disorder (SUD), and Treatment (TX) agencies.	\$ 25,000
Project #: BGCE-RSS33	Create a Dashboard on Healthcare for Workers with Disabilities (HWD)	Public facing dashboard/Marketing on the number of people using the Medicaid buy-in program.	\$ 100,000
Project #: BGCE-RSS35	Implicit Biased Training for Landlords	Braid funding with Commerce to create a training for landlords.	\$ 10,000
Project #: BGCE-RSS36	Funding for SSI/SSDI Outreach, Access, and Recovery (SOAR) Leads	Helping individuals with the creation of a Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) outreach access and recovery community coordinators.	\$ 500,000
BGCE-RSS41	Enhance Mobile Crisis Teams with CPCs	Pilot enhancements to mobile crisis teams by adding CPCs to existing teams.	\$ 1,909,000
Total Recovery Support Services			\$ 6,344,000
Tribal			
Project #	Project Title	Project Description	Proposed Budget

Project #:	BGCE-TRB3	Grants to Tribes and Urban Indian Health Organizations	Provide grants to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver Substance Use Disorder (SUD) prevention, treatment, Opioid Use Disorder (OUD) intervention and recovery support services within their Tribal communities.	\$	861,000
Project #:	BGCE-TRB4	Traditional Healing Pilot Project	Indian Health Care Provider (IHCP) to offer traditional healing/traditional Indian medicine (TIM) services and analyze the health outcomes and potential cost savings from offering Traditional Indian Medicine (TIM) services.	\$	100,000
Total Tribal				\$	961,119
Crisis Set-Aside					
Project #	Project Title	Project Description	Proposed Budget		
Project #:	BGCE-ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding - Crisis Services	Services include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responders (DCR) services.	\$	1,346,000
Total Crisis Set-Aside				\$	1,346,000
TOTAL SABG Covid Supplement Budget					
FEP Set-Aside				\$	2,307,000
Treatment				\$	7,303,372
Recovery Supports Services				\$	6,344,000
Tribal				\$	961,000
Crisis Set-Aside				\$	1,346,000
Administrative				\$	961,000
Total Budget				\$	19,222,372

First Episode Psychosis Project Detail

Project #: BGCE-CYF7

Project Title: Rural and AI/AN Pilot Project for FEP

Proposed Budget: \$2,307,000

Scope:

Develop and adapt evidence based coordinated specialty care (CSC) programs for first episode psychosis (FEP) to meet the needs of rural, frontier and AI/AN communities. The project would be to help to develop a rural and /or Tribal New Journeys/CSC model, to evaluate it, and broadly disseminate the results to inform future program development. Other states are also interested in figuring out how to develop CSC services in rural areas and Tribal communities. There could be great value in collaborating with partners in other states on this (they would fund their own program development) and could help to define rural and AI/AN CSC in other parts of the U.S.

This work is critical to accomplish the legislative mandate in SSSB 5903 requiring statewide expansion of treatment for FEP. Specialized knowledge and adaptation is essential to meet the unique needs of sparsely populated regions and minority communities in order to achieve the goal of decreasing the duration of untreated psychosis. Considering the magnitude of the impact of schizophrenia, interventions designed to treat the disorder effectively at the earliest possible point (e.g., during the first episode of psychosis) have the potential to improve its long-term trajectory, improve outcomes, improve lives, save lives and save health care dollars and to reduce the health care burden of the illness. The longer a person goes untreated, the more severe and chronic their symptoms become, often resulting in decreased functioning and other negative outcomes over their lifetime.

Addressing State Needs and Gaps, Including Gaps in Equity:

Initial examination of 2018 Medicaid data indicate that extra support is needed to ensure that intervention with first episode is equally available in rural geographical areas and in AI/AN communities. The data suggest there are existing geographical disparities and AI/AN disproportionality. The Washington State Legislature, Children's & Youth Behavioral Health work group (CYBWHG) and SAMSHA have all prioritized early identification and intervention for psychosis. This is so screening and early identification of psychosis among adolescents and young adults will become a universal health care practice, and evidence-based recovery interventions will be available to those who need them.

Treatment Projects Detail

Children, Youth and Family

Project #: BGCE-CYF2

Project Title: Developing WISE Workforce Support

Proposed Budget: \$200,000

Scope:

Developing Workforce & Enhancing Local Care Networks to support Youth with Intellectual or Developmental Disabilities including Autism Spectrum Disorder
Three lead Wraparound and Intensive Services (WISE) behavioral health agencies will plan and implement the project informed by local needs with logistical oversight provided the Wraparound and Intensive Services (WISE) Workforce Collaborative/En Route. A training component will be provided by Seattle Children's Autism Center and offered to a total of five (5) Behavioral Health agencies. The proposed RUBI training model will include:

- (1) An initial 16-hour workshop attended by all WISE team providers;
- (2) 20 weeks of ongoing consultation with the WISE team mental health therapist
- (3) Fidelity review of WISE therapist implementation of RUBI sessions

Agencies selected will have been involved in the Health Care Authority and Developmental Disabilities Administration (DDA) convened Wraparound and Intensive Services (WISE) and Intellectual Disabilities/Developmental Disabilities (ID/DD) and Autism Spectrum Disorder (ASD) workgroup or Project Echo sessions. This allows the project to build more directly on the knowledge and efforts already in process.

The three lead agencies will dedicate a portion of a staff time to participate in developing the specialty team model, attend training, learning collaboratives and consultation. Lead sites will also convene community partners to plan for enhancing their local care network to support youth with Intellectual Disabilities/Developmental Disabilities (ID/DD) and Autism Spectrum Disorder (ASD).

Wraparound with Intensive Services (WISE) provides intensive home and community based mental health services to Medicaid eligible children and youth, in compliance with Title XIX of the federal Social Security Act. WISE is available for children and youth 20 years of age or younger who have a serious mental illness.

To receive WISE a child or youth is 1) Medicaid eligible, 2) has a mental health diagnosis and 3) meets the WISE screening algorithm. The WISE screen is to help determine if the youth needs this intensive level of outpatient care.

By design, WISE is a service delivery model for children and youth with the most complex mental health challenges in Washington state. WISE provides individualized, culturally competent services that strive to keep youth with intense mental health needs safe in their own homes and communities, while reducing unnecessary hospitalizations. WISE offers a higher level of care through these core components:

- The Time and Location of services: WISE is community-based. Services are provided in locations and at times that work best for the youth and family, such as in the family home and on evenings and weekends.

- Team-based Approach: Each WISE team includes youth, family members, a WISE care coordinator, a therapist, a Certified Peer Counselor, includes natural supports and members from other child-serving systems when they are involved in a youth's life.
- Help during a crisis: Youth and families have access to crisis services any time of the day, 365 days a year. Youth receive services by individuals who know the youth and family's needs and circumstances, as well as their current crisis plan.

Intensive services provided in WISE include but are not limited to:

- Individual treatment services
- Family therapy services
- Psychiatric medication services
- Crisis mental health services—Outreach services
- Recovery support—Wraparound facilitation services
- Peer support services

References:

- The program, policy and Procedure manual can be found here [WISE Manual](#) and the WISE screening algorithm is available on page 75
- WISE meets the criteria established in the Children's Mental Health Lawsuit under obligations set forth in the [T.R. Settlement Agreement](#)
- [HCA WISE webpage](#)

Addressing State Needs and Gaps, Including Gaps in Equity:

During COVID the increased need of trained staff to provide stabilization support for youth in Wraparound and Intensive Services (WISE) with Intellectual Disabilities/Developmental Disabilities (ID/DD) including Autism Spectrum Disorder (ASD) has become apparent. The concern identifying the need for additional training has been expressed by caregivers, behavioral health agency staff and allied system partners. Our behavioral health workforce is often times generalists by education and don't have the training to best support youth with Autism Spectrum Disorder (ASD) and their families. This funding would provide the training support and consultation to five behavioral health agencies as well as enhance community coordination in three regions for youth enrolled in Wraparound and Intensive Services (WISE) with Intellectual Disabilities/Developmental Disabilities including Autism Spectrum Disorder.

The community coordination and development of this project would include outreach to BIPOC communities to participate and provide insight to specific community needs.

Project #: BGCE-CYF5

Project Title: Trauma Focused Cognitive Behavioral Therapy Training **Proposed Budget:** \$376,671

Scope:

Provide training in Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) to clinicians serving children and youth returning to school as part of the triage process post screening as a part of the recommended Department of Health fast response plan to help meet the needs of children and youth returning to school following the Governor's proclamation that in person options are required as of April 1, 2021. This will serve youth who indicate trauma exposure in the screening process (SED). This is following the Sonoma model, and will further enhance the clinical interventions available to children and youth across WA in the long run.

The Governor issued a proclamation that in person options be available across WA as of April 1, 2021. The potentially unmet needs of children and youth over the past year regarding mental health impact are expected to surface as children youth and families begin the transition to in person education. This proposal meets an identified need in the plans to date that matches the requirements of this funding.

Addressing State Needs and Gaps, Including Gaps in Equity:

The workforce serving children youth and families across Washington are dedicated to the age group and the developmentally appropriate interventions needed. This training further supports them in an evidence-based response to the expected wave of trauma exposure from impacts of the pandemic, to support and serve with resilience and strength-based approaches and supports in pushing back compassion fatigue in ensuring they have the tools they need to feel effective in their work, resulting in resilient communities.

Efforts will be made to ensure training is offered to diverse clinician groups including BIPOC and LGBTQ+ clinician groups.

Adult Treatment

Project #: BGCE-MHA1

Project Title: Cognitive Behavioral Therapy for Psychosis

Proposed Budget: \$130,000

Scope:

This project will expand upon our current contract with the University of Washington's Supporting Psychosis Innovation through Research, Implementation and Training (SPIRIT) Lab to deliver Cognitive Behavioral Therapy for Psychosis to a cohort of outpatient and inpatient clinicians from selected

contracted community-based sites who are serving people receiving 90/180 involuntary civil commitment orders. This Evidence Based Practice (EBP) helps people living with psychosis achieve a level of self-management that has shown great success, supporting individuals and their families in the community.

Many of the people on these long-term involuntary commitments experience psychosis so this Evidence Based Practice is a good fit for the needs of this population. We will train two cohorts of clinicians- each cohort containing staff from an inpatient setting serving people on 90/180 involuntary civil commitment orders and a corresponding outpatient behavioral health agency that treats these individuals upon discharge- or may have treated the individual prior to admission. This will allow the skills learned in either setting to be supported and reinforced in the other setting. The plan is to first train the clinicians to a level of competency such that they then can be trained to supervise others with the model. It would then broaden to be delivered in group treatment and then be the model of treatment across the milieu for those in inpatient settings. We believe that this implementation plan should have good sustainability for these sites.

Training outpatient behavioral health agency staff and their locally corresponding contracted long term civil commitment sites in an appropriate Evidence Based Practice should assist this population in better managing their symptoms and reduce their need for further involuntary or inpatient treatment. This recovery-based model supports both the individual and their family which should help individuals to successfully remain in the community.

Addressing State Needs and Gaps, Including Gaps in Equity:

Training our Behavioral Health workforce in Cognitive Behavioral Therapy (CBT) for Psychosis will help empower individuals living with psychosis to better manage symptoms that interfere with their ability to live their lives in the community. The Behavioral Health workforce needs enhanced tools to treat psychosis beyond simply medication alone. This evidence-based practice is targeted to the needs of a population that traditionally does not receive therapy as many clinicians do not know about Cognitive Based Therapy (CBT) for Psychosis and its success rate. Additionally, the facilities that have begun to take individuals on long term orders have reported a need for more enhanced programming for this population and it is important to provide continuity of care, including support for skills development, across care settings.

People living with psychosis experience much social isolation due to their symptoms. By providing them with greater skills to manage psychosis, this inequity will be better addressed. This enhancement will serve all populations living with psychosis, including members of BIPOC communities but is not a targeted outreach to them specifically.

Project #: BGCE-MHA2

Project Title: Trauma Informed Care for Designated Crisis Responders **Proposed Budget:** \$50,000

Scope:

Modify curriculum of Trauma Informed Care Training specifically for Designate Crisis Responders so that Designated Crisis Responders (DCR) can incorporate the skills into their practice. Conducting involuntary treatment investigations can be innately traumatizing. Incorporating trauma informed techniques into the Designative Crisis Responder (DCR) skill set can help make the investigations less traumatizing, and hopefully minimize long term trauma from the involuntary treatment process.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently no trauma informed care training specific to the work Designative Crisis Responders do. Involuntary Treatment Act (ITA) evaluations can be traumatizing for the people performing the evaluation. To minimize the impact to the Designated Crisis Responders, the individuals being evaluated and the system as a whole, this training is immediately necessary.

Individuals in BIPOC communities and those with serious behavioral health issues are more likely to have encounters with law and healthcare systems that result in furthering trauma. The trauma that effects the individual being evaluated also impacts the person doing the evaluation. Proper training can help improve the interactions between Designated Crisis Responders, law enforcement and individuals receiving treatment. This will assist in more sustainable recovery for every individual, and a system prepared to support those in need.

Project #: BGCE-MHA3

Project Title: Mental Health Specialist Training

Proposed Budget: \$396,329

Scope:

Develop curricula for a 100-hour course for Mental Health Professionals who provide treatment services to individuals with SMI or SED to secure credential to become an Older Adult Mental Health Specialist, Intellectual Disabilities/Developmental Disabilities (ID/DD) Mental Health Specialist, and Ethnic Minority Mental Health Specialist as defined in Washington's Rehab State Plan for Mental Health Outpatient (OP) treatment. Training curricula will focus on recognizing unique needs of these populations, clinical best practices, understanding of the community resources and partners when working with these populations, the role of Mental Health Specialist and how to provide clinical consultation, cultural humility, and other relevant information specific to each demographic.

The Division of Behavioral Health and Recovery (DBHR) has not sponsored Mental Health Specialists academies for almost ten years and as such, there are significant workforce shortages in specialists trained and credentialed to work with the older adult population, individuals with intellectual and developmental disabilities, and ethnic minorities. Each of these populations has unique needs or considerations that impact care and the behavioral health workforce needs additional training and supports in order to meet their needs. The overall intent is to provide better care for clinicians who provide services to SMI and SED populations.

Addressing State Needs and Gaps, Including Gaps in Equity:

With a fast-growing aging population, the need for mental health professionals trained and sufficiently skilled to work with older adult population is more critical than ever. The current workforce requires

specialized skills and knowledge to better support BIPOC populations and people with Intellectual Disabilities/Developmental Disabilities. This is a work force shortage that must be addressed.

BIPOC communities, older adults, and people with Intellectual Disabilities/Developmental Disabilities must receive culturally appropriate services from clinicians with relevant education, experience, and skills. This is a matter of equity and parity.

BH-ASO Treatment Funding

Project #: BGCE-ASO2

Project Title: Behavioral Health Administrative Services Organization (BH-ASO) Treatment Funding
Proposed Budget: \$6,150,372

Scope:

Funding directed to the Behavioral Health Administrative Services Organizations (BH-ASO) will support their respective provider networks enhancing the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. This includes a regionally based system of care that includes mental health services to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities. Including increasing capacity of Designated Crisis Responder (DCR) and Tribal Designated Crisis Responder (DCR) services.

The community mental health services are provided to individuals with serious mental illness/serious emotional disturbance including specialized outpatient services for American Indian/Alaskan Native (AI/AN), children, and the elderly. Services provided include but are not limited to outpatient services for individuals who have been **discharged** from inpatient treatment, day treatment, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, and individuals residing in rural areas. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retainment issues that have increased throughout the behavioral health delivery system during the pandemic.

If funding were not approved the statewide behavioral health service delivery system will continue to face funding gaps, service delivery delays, and individuals diagnosed with Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED) will be less likely to have opportunities to access services and function better in their communities experiencing an improved quality of life. Further, an opportunity to

enhance and improve ongoing behavioral health system workforce recruitment and staff retention worsened by the pandemic will be missed.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support, and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that policies and procedures have had negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation.

Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based behavioral health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments.

Recovery Support Services Projects Detail

Project #: BGCE-RSS1

Project Title: Participant Support Funds – Housing and Recovery through Peer Services (HARPS) Teams
Proposed Budget: \$50,000

*Additional \$50,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice example. This project would provide funds directly related to benefit participants in the HARPS program to assist individuals who are transitioning from inpatient settings to the community. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

We expect the housing crisis and behavioral health crisis to intensify as eviction protections are lifted. The Housing and Recovery through Peer Support (HARPS) priority population is unable to earn wages while involved with inpatient treatment and is unlikely to have savings to secure housing upon discharge. Additionally, many participate intensive outpatient treatment which limits the amount of time to earn wages to afford housing, as well as other necessities to stay engaged in treatment and recovery activities.

Adding additional support funds to each Housing and Recovery through Peer Services (HARPS) contract to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination of other healthcare services and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Participant Support Funds will help the Housing and Recovery through Peer Support (HARPS) Teams to interweave care coordination, case management, and outreach services. People experiencing homelessness and behavioral health conditions benefit from connections to peer services and resources.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS2

Project Title: Participant Support Funds – Projects for Assistance in Transition from Homelessness (PATH) Teams
Proposed Budget: \$140,000

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice example. This project would provide funds directly related to benefit participants in the homeless outreach teams to assist individuals who are seriously mentally ill and not engaged in treatment. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

Proposed support service funds will be added to the current contracted programs, Projects for Assistance in Transition from Homelessness (PATH). PATH programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency will be required to develop a detailed plan describing method and intended outcome for allocating client support service funding and submit to the Health Care Authority for approval by 09/30/2021. Plan must be based on Mental Health Block Grant (MHBG) guidance for Target Population* and Statement of Work.

Persistent and consistent outreach and providing services at the individual's pace are important steps to engage people with serious mental illness who are homeless. The proposed support service funds will enhance the quality of program delivery and engagement and expand critical client resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

Homeless outreach services intention is to reach individuals who are not currently engaged in services and potentially unable to navigate the system. The ability to have support services that offer basic needs upon engagement increases the likelihood for engagement in treatment and recovery.

PATH teams serve individuals experiencing homelessness and Serious Mental Illness (SMI) to BIPOC communities. BIPOC communities are overrepresented in homelessness. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: BGCE-RSS3

Project Title: Participant Support Funds – Peer Bridger
Proposed Budget: \$100,000

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with

Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

- COVID-19 related expenses for those with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED), including testing and administering COVID vaccines, COVID awareness education, and purchase of Personal Protective Equipment (PPE).

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice example. This project would provide funds directly related to benefit participants with serious mental illness who are transitioning from inpatient settings to the community. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

The goal of this project is to use participant funds to connect people to community supports and treatment and reduce recidivism to the state hospital admissions. Keeping individuals engaged in peer services creates personal connection, accountability, and someone to assist in navigating complicated systems. Without these added supports the system continues to be a revolving door for many.

MHBG Funds could be used to support case managers, outreach workers, Assertive Community Treatment Services For people experiencing homelessness, medications, coordination with primary care, and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support improves engagement and increases hope by modeling recovery. These complimentary services will enhance the already proven Peer Bridger model.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS7

Project Title: Certified Peer Counselor (CPC) Online Continuing Education Bank

Proposed Budget: \$50,000

*Additional \$50,000 SABG

Scope:

This funding would be used to create online Certified Peer Counselor (CPC) continuing education trainings. The trainings could include Wellness Recovery Action Plans (WRAP), Crisis Plans, Suicide Prevention, cultural awareness, and others. The goal is to great online learning bank for Certified Peer Counselors where they can access continuing education trainings on demand.

These trainings would be accessible for all certified peer counselors in Washington and the knowledge gained will improved peer services provided in Washington. Traditionally Certified Peer Counselors (CPCs) continuing education trainings have been funded by DBHR, during the past year we have had to reallocate funding to meet the needs of the Certified Peer Counselor workforce by increasing our core Certified Peer Counselor (CPC) trainings. These online trainings will be able to be accessed by peers across the state no matter where they reside or work and removing barriers to access. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors (CPCs).

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors (CPCs) are effective in increasing recovery outcomes in mental health and Substance Use Disorder (SUD). Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors. Continuing education for certified peer counselors is always requested and providing these trainings in a virtual format will make the trainings more accessible to peers in all areas of the state.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS8

Project Title: Foundational Community Support (FCS) Supported Housing/Supported Employment (SH/SE) Fidelity Reviewer Certification

Proposed Budget: \$50,000

*Additional \$50,000 SABG

Scope:

Intensive Trainings for Foundational Community Supports (FCS) providers to increase their skills/trainings on SAMSHA Permanent Supportive Housing (PSH) Fidelity Reviews and Individual Placement and Support (IPS) Support Employment Fidelity Reviews.

Washington State Foundational Community Support programs uses two evidence-based models- SAMSHA Permanent Supportive Housing and WESTAT/Rockville Institutes Individual Placement and Support Supported Employment Model. To ensure high quality standards and fidelity to these models, Foundational Community Support (FCS) providers participate in fidelity reviews. This funding will allow Foundational Community Support provider to participate in intensive training to able to provide high quality fidelity reviews and ensure compliance with the evidenced based practices.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal justice interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a way out of poverty and prevent entry into the disability system. The Individual Placement and Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trails that demonstrated implementing Individual Placement and Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive employment as compared to individuals not receiving Individual Placement and Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement and Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

Foundational Community Supports utilizes the evidence-based practices of SAMSHA's Permanent Supportive Housing and Westat's individual placement and support. The principles of these evidence-based practices encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. These services also value and approach participants with equity, respect as well as cultural humility with the hope of promising outcomes.

Project #: BGCE-RSS9

Proposed Budget: \$50,000

Project Title: Community Work Incentive Coordinator (CWIC) Training and Staffing Costs

Scope:

This project proposes to use MHBG funds to cover Staff training costs for community behavioral health agencies to become Community Work Incentive Coordinators. Nothing provides 'hope' more than believing that people can work but addressing an individual's concerns about how working affects their governmental benefits is key to implementing the evidence-based practice model called Individual Placement and Support. Benefits counseling is one of the core principles of providing this EBP model.

Washington State's Foundational Community Supports (FCS) supported employment providers serve individuals using the Evidence Based Practice of Individual Placement and Support, the program developed and managed by Westat Rockville Institute. Washington state legislature mandated the use of evidence based or promising practices when Foundational Community Support (FCS) was approved. The intent is for the service to be statewide and in order to positively impact sustainability, services should be provided to fidelity in order to achieve the greatest outcomes. An important element of the principles of Individual Placement and Support is the education of job seekers of how income may impact federal and state benefits and entitlements. There is currently not the bandwidth in Washington's State to provide work incentive education and planning to enroll individuals in the Foundational Community Support system. The proposal is to send Foundational Community Support (FCS) agency staff from agencies to enroll in webinars to learn the foundational knowledge of Social Security work incentives, and to secure certification training for select agency staff at behavioral health organizations in Western and Eastern Washington State. This initiative will greatly increase the number of benefit practitioners to education and support job seekers in the transition to competitive employment, attain self-sufficiency while decreasing reliance on public entitlement programs. The Institute on Employment and Disability in Cornell University's Industrial and Labor Relations School training also has a credentialing option that provides a pathway to be recognized as an accredited work incentive planner. Work incentives pave the way to work and financial independence for recipients of public benefits. This training will provide essential insight into how the complex mix of work incentives, critically needed benefits, and earnings can be explained to an individual with a disability to encourage both work and financial independence.

There is a critical need for the training of benefit education planners in Washington State. The Foundational Community Support (FCS) program has 162 providers with 458 service location, with an enrollment of over 3,000 individuals. the availability of agency staff with foundational knowledge and access to certified benefit planners is crucial to provide support to enrolled participants and learn how earned income can impact entitlement benefits. These training opportunities will provide staff essential tools to assist job seekers to reach their individual goal of self-sufficiency. The implementation and practices of the Individual Placement Support (IPS) supported employment model are expanding in Washington State, and the critical need to adequately prepare agency staff of benefit planning curriculum is essential for overall long-term success. The certification training through the Institute on Employment and Disability in Cornell University's Industrial and Labor Relations School will prepare agency staff to support enrolled participants to develop a clear, comprehensive, and actionable report of an individual's financial situation and how to maximize self-sufficiency trends. There is not currently a more viable way to increase skills of agency staff and to increase the numbers of certified benefit planners.

Addressing State Needs and Gaps, Including Gaps in Equity:

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a way out of poverty and prevent entry into the disability system. The Individual Placement Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trails that demonstrated implementing Individual Placement Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive employment as compared to individuals not receiving Individual Placement Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

The Foundational Community Support Program is built upon evidenced based practices of SAMHSA and the Westat Rockville Institute to implement supported employment practices that are effective. The principles of these evidence-based practices (EBP) encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. The struggles of poverty and self-sufficiency negatively impact communities of people of color disproportionately. The implementation of based practices accelerates the positive impact on social determinants of health in urban and rural communities. Services are provided are inclusive of all who need them and targeted to individuals with a wide range of disabilities.

Project #: BGCE-RSS10

Project Title: Intentional Peer Support Training

Proposed Budget: \$150,000

*Additional \$150,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

These funds will be used to train Certified Peer Counselors in Intentional Peer Support. These trainings will be provided either in person or in a virtual format depending on physical distancing requirements. Priority for these training will be Certified Peer Counselors (CPCs) who work on the following teams Peer Bridgers, Housing and Recovery through Peer Services (HARPS), Forensic Housing and Recovery through Peer Services (HARPS), Projects for Assistance in Transition from Homelessness (PATH), Forensic Projects for Assistance in Transition from Homelessness (PATH), Peer Pathfinders, and Foundational Community

Support (FCS) teams. The training will be opened up to additional Certified Peer Counselors (CPCs) when space is available. This funding will also be used to provide travel supports for participants.

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors (CPCs) are effective in increasing recovery outcomes in mental health and Substance Use Disorder. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (EDI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS12

Proposed Budget: \$1,120,000

Project Title: Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disorder (SMI/SED).

Scope:

Proposed funds will add one peer counselor to each of the current Projects for Assistance in Transition from Homelessness (PATH). Project for Assistance in Transition from Homelessness (PATH) programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency will be required to hire and onboard a new peer counselor to expand outreach and engagement services for individuals with a serious mental illness (SMI) and homeless or at risk of homelessness. Projects will work closely with BHASO's, Managed Care Organization's (MCO's) and Crisis stabilization centers to create a referral flow and coordination of services.

The proposed expansion of adding one additional Projects for Assistance in Transition from Homelessness (PATH) peer counselor to each of the Projects for Assistance in Transition from Homelessness (PATH) teams will allow agencies to expand needed outreach and engagement efforts. The proposed funds will enhance the quality of program delivery and engagement and expand critical crisis resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

The intention of Homeless outreach services is to reach individuals who are not currently engaged in treatment, services and who are potentially unable to navigate the system. The ability to have one additional peer outreach team member will allow these programs to broaden the current outreach and engage services to a primary focus of crises response.

Projects for Assistance in Transition from Homelessness (PATH) teams currently serve individuals experiencing homelessness and mental illness and BIPOC communities. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: BGCE-RSS13

Project Title: Creating a Behavioral Health Housing Action Plan

Proposed Budget: \$15,000

*Additional \$15,000 SABG

Scope:

In 2007, the Mental Health State Transformation Initiative generated a Housing Action Plan. The Housing Action Plan conducted an inventory of affordable housing for people with serious mental illness, set a philosophical approach for Housing First principles and identified action steps to improve affordable housing. This proposal seeks to update the Housing Action Plan to include people with substance use disorders.

Washington is experiencing a significant housing crisis. Individuals with behavioral health conditions experience homelessness at a significant rate. The development of a housing action plan will create a north star for the behavioral health system to pursue partnerships to create and develop affordable housing.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will identify and analyze the needs and gaps for affordable housing for the behavioral health population. It will develop an action plan to meet the affordable housing needs of individuals with both mental health and substance use disorders.

The Behavioral Health Affordable Housing Action plan will analyze the impacts of homelessness on the BIPOC population. According to Research and Data Analysis, individuals experiencing homelessness are more likely to be African American or Alaska Native/American Indians (Ford-Shah, M., 2012)

Project #: BGCE-RSS14

Project Title: Creating a Housing Inventory/Estimator/Calculator

Proposed Budget: \$150,000

*Additional \$150,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Prison and jail re-entry and enhanced discharge from inpatient settings in order to reduce risks of COVID-19 transmission.

Scope:

The Research and Data Analysis Division (RDA) within the Department of Social and Health Services (DSHS) completed a series of reports in 2012 examining the housing status of individuals following their exit from institutional or out-of-home care settings. More than one-quarter of all five study populations (individuals leaving Substance Use Treatment Facilities; State Department of Corrections Facilities; Foster Care; State Mental Hospitals and Juvenile Rehabilitation Facilities) experienced homelessness at some point over a 12-month follow-up period. This project will create an online searchable tool based on various scenarios to connect individuals with behavioral health conditions to housing. Based on a current algorithm currently housed in the Pathways to Employment Site, Research and Data Analysis will create a housing version for the Pathways to Housing site.

This searchable tool that will be housed on the Research and Data Analysis Pathways to Housing site will be used to help address the fact that almost 50 percent of Individuals leaving residential substance use treatment facilities became homeless within the year of discharge. Individuals exiting prison, foster care, State Mental Hospitals, and Juvenile Rehabilitation facilities were more likely to experience homelessness but as likely to obtain to permanent housing when they received housing assistance. Across the five study populations, the proportion of individuals in need of housing who received Homeless Management Information System (HIMS)-recorded assistance was highest for youth aging out of foster care (at 35 percent). Even though this report is dated, it is believed these relate to the population we intend to start with: individuals with behavioral health issues still exist and may even be more exacerbated with the COVID pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will provide timely information for individuals with behavioral health conditions to access housing services and resources.

The searchable housing tool will ensure individuals with Behavioral Health conditions and part of the BIPOC population will have access to housing services and resources.

Project #: BGCE-RSS15

Project Title: Peer Dashboard

Proposed Budget: \$100,000

*Additional \$100,000 SABG

Scope:

This funding would be used to create a Dashboard for the Peer Support Program. This would enable the team to see data pulled from the Peer Support database on an easily accessible format. There is increased focus on the peer support program to meet the growing workforce needs. This dashboard would allow the Health Care Authority to have immediate access to data for updates to lawmakers and stakeholders. Without the dashboard the Peer Support Team and leadership would not have easily accessible data about the Peer Support Program.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is a Behavioral Health workforce shortage in Washington and peer services are a growing workforce that can help to meet the Behavioral Health needs of our communities. The dashboard will allow the Division of Behavioral Health and Recovery easy access to data that could direct the Peer Support Program where to focus trainings where gaps are identified to increase the Certified Peer Counselor (CPC) workforce and the diversity of the Certified Peer Counselor workforce.

Programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS17

Proposed Budget: \$15,000

*Additional \$15,000 SABG

Project Title: White Paper/Toolkits/Medicaid Academy for Peer-Run Peer-Operated Agencies

Scope:

This funding would be used to create a white paper to explore strategies for peer run/peer operated agencies to become licensed community behavioral health agencies so that they will be able to bill Medicaid for peer services.

This would provide technical assistance for clubhouse and consumer run organizations to become licensed providers and bill Medicaid for peer services. This will increase recovery support services to a larger portion of the state. Washington State supports several clubhouse programs using general fund dollars and SB 5328 is proposing that the state go farther in helping clubhouses gain access to Medicaid funds. This project aligns with the bill to assist those organizations to bill Medicaid.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently a shortage of behavioral health workers across Washington State. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. This would allow additional agencies to become licensed to provide peer services increasing the availability of Mental Health and Substance Use Disorder (SUD) peer services to a larger population. If unfunded, this technical assistance will not be available in the state and could delay agencies in getting licensed to provided peer services.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS18

Proposed Budget: \$50,000

*Additional \$50,000 SABG

Project Title: Foundational Community Support (FCS) – Converting Current Training to Online Training Modules

Scope:

Foundational Community Supports (FCS) provides supported employment and supportive housing services across the state of Washington with over 160 agencies contracted to provide Foundational Community Support (FCS) services. The Division of Behavioral Health and Recovery (DBHR) has four full time trainers who provide technical assistance to Foundational Community Support (FCS) providers. The growth of Foundational Community Support (FCS) has increased the need for technical assistance/training and the Division of Behavioral Health and Recovery (DBHR) would like to convert some of the "stock" training that it provides to all new Foundational Community Support (FCS) providers to a virtual format. Creating online training modules of stock trainings currently provided in person will free up time for Foundational Community Support (FCS) trainers to provide more individualized, targeted, and intense technical assistance.

This project is critical to maintaining and improving the quality of services provided by Foundational Community Support (FCS) providers. Focused, targeted, and high-level training ensures consistency and adherence to the evidence-based modules that Foundational Community Support uses. Currently, the Division of Behavioral Health and Recovery Foundational Community Support trainers are spending

much of their time delivering stock training to providers as they onboard new staff. This type of training could easily be provided in a virtual recorded format that would free up the Foundational Community Support (FCS) trainers time to provide more advanced targeted technical assistance to providers. Freeing up the Foundational Community Support (FCS) trainers time to focus on more targeted and nuanced technical assistance allows us to grow the quality of the Foundational Community Support program.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal justice interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery. Being productive is a basic human need. Working can both be a way out of poverty and prevent entry into the disability system. The Individual Placement Support (IPS) model of supported employment is an evidence-based strategy that has utilized 28 randomized controlled trails that demonstrated implementing Individual Placement Support (IPS) services resulted in significant rates of employment, as much as 3 times as many people successfully achieving competitive employment as compared to individuals not receiving Individual Placement Support (IPS) services. Employment has many positive impacts on the mental health and wellbeing of individuals with psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Expanding the philosophy of Individual Placement Support (IPS) supported employment, and improving the quality of training to direct staff, will maintain the trend of improved employment outcomes across all communities.

Foundational Community Supports utilizes the evidence-based practices of SAMSHA's Permanent Supportive Housing and Westat's individual placement and support. The principles of these evidence-based practices encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. These services also value and approach participants with equity, respect as well as cultural humility with the hope of promising outcomes.

Project #: BGCE-RSS19

Proposed Budget: \$500,000
*Additional \$500,000 SABG

Project Title: Cover Foundational Community Support (FCS) Services in Institution of Mental Disease (IMD) When Medicaid is Suspended

Scope:

The Division of Behavioral Health and Recovery proposes to utilize block grant funds to cover Foundational Community Support services for people transitioning out of Institution of Mental Disease (IMD) settings if the Medicaid isn't retroactively reconnected. The Foundational Community Support (FCS) program assists eligible individuals with complex health needs obtain and maintain stable housing and can provide Foundational Community Support services within short-term Institution of Mental Disease (IMD) settings with housing assessments and begin the housing acquisition process prior to discharge. These newly added services to Foundational Community Support will include coaching, advocacy, information and referral, linking and coordinating, and ongoing supports that they may not otherwise have access to.

The program offers an array of transition/pre-tenancy and tenancy-sustaining supports that have been effective in improving housing stability, health and employment outcomes for high need Medicaid beneficiaries. linking and coordinating, and ongoing supports that they may not otherwise have access to. Many of these individuals have complex health profiles and face multiple housing related barriers to effectively engaging with health care systems and managing their own plan of care to achieve improved health and wellness. Foundational Community Support have reduced the frequent use of emergency department and inpatient care, addressed significant gaps in connections to care, addressed homelessness, and now can help to facilitate timely, successful transitions from institutional settings to integration in community placements. Anticipated Outcomes:

- Effectively target interventions to eligible individuals in residential treatment settings;
- Streamline and standardize transition and tenancy-sustaining services for individuals exiting residential treatment across agencies and systems;
- optimize and braid all available funding to fill gaps;
- reduce Substance Use Disorder/Opioid Use Disorder (SUD/OD) related deaths;
- improve Substance Use Disorder system capacity; and
- improve quality of care

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is no other mechanism to reimburse Foundational Community Support providers if the individuals Medicaid is not active at the time of authorization. The Health Care Authority has taken steps to attempt to mitigate this by providing Foundational Community Support providers access to Provider One to check Medicaid eligibility. This however is not a perfect solution and there are times when Foundational Community Support providers go unpaid.

The Foundational Community Support program is based on the evidence-based practices (EBP) of Permanent Supportive Housing (PSH) and Individual Placement and Support (IPS). The principles of these Evidence-Based Practices encompass equity and racial justice through the promotion of choice, flexible voluntary services, and access.

Project #: BGCE-RSS20

Project Title: Peer Wellness Coach Training

Proposed Budget: \$15,000

*Additional \$15,000 SABG

Scope:

These funds would be used to bring either Peggy Swarbricks Wellness coaching or Pat Deegan's Personal Medicine Coach certification training to Certified Peer Counselors. Pat Deegan's program can also bring a train the trainer to Washington so that we can training Certified Peer Counselors in Personal Medicine Coach training.

This project will provide continuing education to certified peer counselors in Washington State around. The intended outcome is to increase the knowledge of certified peer counselors to even more effectively support the peers they serve. Both programs focus on increased health outcomes. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors.

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is a workforce shortage of behavioral health workers. Certified Peer Counselors are effective in increasing recovery outcomes in mental health and Substance Use Disorder (SUD). Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. If unfunded, this training will not be available in the state or will be out of reach financially for most Certified Peer Counselors. This continued education will provide information to better support people in whole health as we are moving to a more integrated approach to who person care.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices, and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS22

Project Title: Training for Oxford Outreach Staff

Proposed Budget: \$20,000

*Additional \$20,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

DBHR currently funds 10 outreach staff that provide support to the 300+ Oxford houses in Washington State. Individuals with co-occurring SMI and SUD diagnosis are recipients of the mutual support received within an Oxford house. This proposal is to fund training for the 10 outreach staff to better

support the individuals with co-occurring serious mental illness and substance use disorders. Training topics include but not limited to de-escalation, mediation, grief counseling etc.

We would like to add funding for training Oxford House Outreach Workers. There have been too many deaths in the Oxford Houses since COVID-19 started due to isolation and the feelings of hopelessness which brings an increase in drug and fentanyl use and ultimately relapses and deaths. Therefore, there is a need for the 10 Oxford House Outreach Representatives to get trainings on de-escalation, grief and loss, relapse prevention, meditation, Dialectical Behavioral Therapy (DBT), and any other training that would benefit the Oxford House Representatives in helping the residents deal with their grief, losses and fears of relapse.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Oxford House Sober Recovery Homes fills a gap in the substance use disorder services continuum by establishing and maintaining self-run, self-supported peer-operated sober recovery homes. In adherence with United States Code, Title 42, Section §300X–25 Group Homes for Recovering Substance Abusers, the State Agency will utilize the Oxford House concept to increase sober recovery housing assistance opportunities for recovering individuals living together in a residential disciplined environment to maintain recovery without recurrence of use. This level of care includes the provision of a safe and affordable home, in a drug-free living situation to recovering individuals with the support of other peers in recovery, Contractor staff, and other supports and services in the community including mental health guidance from outreach representatives who are trained.

Adult men and women completing residential treatment or are currently in outpatient treatment for substance use disorder, as well as those enrolled in recovery support, and opioid treatment services, who need a place to live and can meet the requirements for being a resident of a Recovery House. People leaving prisons and jails, Oxford House has a strong re-entry program with Department of Corrections (DOC) and does not discriminate on anyone's culture, race, or mores. Recovery housing will also include populations with a reported history of opioid use disorder (OUD) and opioid use.

Project #: BGCE-RSS23

Project Title: Participant Engagement Kits for Youth – Mockingbird

Proposed Budget: \$35,000

*Additional \$35,000 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

Scope:

Per the SAMHSA letter dated March 11, 2021, States are encouraged to use the recently developed SAMHSA Crisis Services: Meeting Needs, Saving Lives report. According to that report, flexible funds to support staff who link people with serious mental illness or co-occurring SMI and SUD who are willing but not otherwise engaged with housing, treatment, and supports are considered a best practice example. This project would provide funds directly related to benefit participants in homeless outreach teams to assist individuals who are seriously mentally ill and not engaged in treatment. Expenses could include but not limited to transportation costs, PPE and items needed to support their recovery.

The Mockingbird Society creates, supports, and advocates for racially equitable, healthy environments that develop young people at risk of or experiencing foster care or homelessness. The Youth Advocates Ending Homelessness in Washington state report an alarming number of youth experience mental health, substance use disorders and health crisis. This includes advocates that report individuals who are experiencing medical issues that may or may not receive medical treatment. The inability to care for wounds will likely cause more server health issues or worse. Proposing funding for Mockingbird Outreach for Homeless Hygiene and wound care kits such as hand sanitizer, antiseptic, rubbing alcohol, hydrogen peroxide, ointment, band aids, gauze, and pain relievers could make the difference.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Mockingbird Society of Washington report Homeless youth lack access to medical care and often go without essential hygiene and wound care items which are not covered by Medicaid.

The Mockingbird Society creates, supports, and advocates for racially equitable, healthy environments that develop young people at risk of or experiencing foster care or homelessness.

Project #: BGCE-RSS24

Project Title: Peer Pathfinders Transition from Incarceration Pilot

Proposed Budget: \$790,000

*Additional \$790,000 SABG

Scope:

This funding will add a Certified Peer Counselor to up to five existing BH-ASO contracts for jail transition services. Adding a Certified Peer Counselor to existing jail transition services teams will increase the level of services being provided, by having a CPC connect with the individuals while they are still in jail and helping them with transition to the community. The certified peer counselor will work with individuals diagnosed with a serious mental illness, linking them to behavioral health services, including co-occurring treatment, Foundational Community Support (FCS), and other applicable services.

Multiple studies support the fact that Peer support services has significant impacts on quality of life, reducing substance use, and improving positive social supports. Studies have also identified common elements of peer support, suggesting possible processes that underlie effective peer support. Peer services include shared experiences, role modelling, and positive social support. All of which are suggested to be vital aspect of peer support and moderate positive life changes. By adding a certified peer counselor to existing Jail Transition services allows for access to these vital services for individuals with SMI and co-occurring health conditions, reducing likelihood for further court involvement. Impacts that are likely to occur if this project is not approved included recidivism because the individual was not provided the needed services during their jail transition.

Addressing State Needs and Gaps, Including Gaps in Equity:

People exiting jails are more likely to be successful when they are able to connect and engage in services in their communities upon release. Currently in some parts of the state jail transition services are only reaching jail populations a few times a month. By adding a Certified Peer Counselor to existing jail transition services, individuals who are in need of extra support in accessing community-based services can be offered the support of a peer. These certified peer counselors would focus on linking individuals

to behavioral health services, including co-occurring treatment, housing and employment, and community resources.

A disproportionate number of individuals of color are represented in our criminal court system and they experience greater barriers in accessing healthcare and community behavioral healthcare. This problem is greater amplified the further away you move from urban settings and locations in which more services are available. By adding the support of a Certified Peer Counselor to existing jail transition services, this will increase the likelihood of individuals being able to overcome some of these barriers.

Project #: BGCE-RSS25

Project Title: Add Co-Occurring Peer to F-HARPS

Proposed Budget: \$400,000

*Additional \$400,000 SABG

Scope:

These additional funds would allow the teams to hire another certified peer counselor for each Forensic HARPS team in the phase 1 regions. With this additional staff person, the teams would be able to increase caseload capacity. This position would also allow the Forensic HARPS teams to serve individuals diagnosed with serious mental illness or co-occurring.

This project is critical because it will increase the capacity of the teams to serve more eligible individuals through the Forensic HARPS program, an element of the Trueblood Settlement. Housing access, support, and short-term subsidies increase an individual's opportunity for recovery. Housing is a basic need that reduces the likelihood of recidivism in the criminal court system. If this funding is not approved, the Forensic HARPS teams will not be able to serve all those who are eligible and in need of this service.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Forensic HARPS teams have short-term housing subsidy dollars to assist participants in obtaining and maintaining housing. The amount of subsidy dollars allocated to each team is greater than what the current staffing model allows them to spend. With this additional staff person, the Forensic HARPS teams will be able to fully utilize the subsidy dollars allocated to them. Funding Forensic HARPS teams is cost effective because it diverts individuals with serious behavioral health conditions into receiving the services, they need instead of being arrested or hospitalized. Supportive housing reduces inpatient hospitalization, incarceration and engagement in outpatient treatment increases when individuals are successfully housed (RDA, FCS preliminary outcomes 2020).

Helping individuals obtain and maintain housing of their choice helps them be more successful in treatment. Forensic HARPS teams are trained in leveraging all community resources once an individual exits jail or an institutional setting, but the 'bridge subsidy' is still needed in order to assist individuals exit jail as quickly as possible.

A disproportionate number of individuals of color are represented in our criminal court system. Many of these individuals experience significant barriers in accessing safe and affordable housing. WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. People with trauma, a history of homelessness, and co-occurring disorders have an increased likelihood of being involved in the criminal

court system. Helping individuals find and maintain housing of their choice, and obtain wanted services, especially during an increased time of hardship such as COVID-19 is our states responsibility.

Project #: BGCE-RSS32

Project Title: Operationalizing Peer Bridger

Proposed Budget: \$25,000

*Additional \$25,000 SABG

Scope:

This funding will be used to create an Operationalizing Peer Support training for the peer Bridger program for jails, hospitals and Substance Use Disorder (SUD) treatment agencies. Operationalizing Peer Support trainings provide Technical Assistance (TA) to existing and new agencies who need support with their peer program or who want to implement peer services. This training would also be to provide technical assistance to the jails, hospitals and inpatient setting who will be collaborating with the peer Bridger program.

As we transition the peer Bridger from providing services at the state hospitals into community-based hospitals and inpatient settings, technical assistance will be beneficial in the transition for the agencies, hospitals, and the peer Bridger program. If not approved, there will be confusion about the peer Bridger program and how to effectively utilize the services resulting in people not receiving these recovery support services. This could increase recidivism into an inpatient setting.

Addressing State Needs and Gaps, Including Gaps in Equity:

There is currently a shortage of behavioral health workers across Washington State. Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. We are currently witnessing gaps in service since the 90/180-day beds went live last year. This needed TA would be able to provide the necessary support and education to effectively utilize the peer Bridger program increasing recovery supports in inpatient settings.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS33

Proposed Budget: \$100,000

Project Title: Create a Dashboard on Healthcare for Workers with Disabilities

Scope:

Washington's Healthcare for Workers with Disabilities is the Medicaid Buy-in Program. Nothing provides 'hope' more than believing that people can work but addressing an individual's concerns about how working affects their governmental benefits is key to implementing the evidence-based practice model called Individual Placement and Support. Benefits counseling is one of the core principles of providing this EBP model. Part of benefits counseling is to help individuals access work incentives such as the Medicaid Buy-in Program to ensure working doesn't have adverse effects to their receipt of services or medications. This project would promote this untapped work incentive program/Medicaid Buy-in program through the creation of a marketing campaign and public dashboard on the utilization of the benefit. According to Research and Data Analysis in the 2nd quarter of 2020, only 12 percent of disabled individuals with a serious mental health issue were employed in Washington State. (10,631/88,381). There are currently 1606 individuals in WA on HWD.

The Apple Health for Workers with Disabilities (HWD) program recognizes the employment potential of people with disabilities and represents Washington State's response to the landmark "Ticket to Work" legislation passed by Congress in 1999. Healthcare for Workers with Disabilities (HWD) is an underutilized program within the state of Washington. This is a critical program to provide low-cost healthcare for people with disabilities, enabling people with disabilities to no longer have to choose between taking a job and having health care, and therefore work to their full potential. Marketing needs to include the message that self-sufficiency is attainable. There is a need to communicate measurements of number of individuals using the service as a part of marketing the program. This proposal is to develop a public facing dashboard as a part of marketing. There will be collaboration between the Health Care Authority departments that have Healthcare for Workers with Disabilities (HWD) as part of the service provided, with the communications department, and with Research and Data Analysis in order to come up with an attractive and fully functioning site that provides current and accurate data.

The benefit to the government is shifting individuals off of benefits and having them add to tax revenue. Under Healthcare for Workers with Disabilities, people with disabilities can earn more money and purchase health care coverage for an amount based on a sliding income scale.

Healthcare for Workers with Disabilities benefits include:

- Medicaid benefit package
- Access to long term services and supports, if functional requirements are met
- Greater personal and financial independence
- Members can earn and save more without the risk of losing their healthcare coverage

If not approved, people with disabilities have less encouragement to work and continue to live below the poverty level while remaining on public benefits. It disproportionately negatively impacts ethnic minorities.

Addressing State Needs and Gaps, Including Gaps in Equity:

Washington state is challenged by low competitive employment outcomes of individual with serious mental illness and disabilities. Historically, over 60% of people with serious mental illness want to work but only 15% are employed. Only 2% of people have access to effective employment services. They see work as an essential part of recovery, but many avoid seeking work due to fear of losing benefits. Employment has many positive impacts on the mental health and wellbeing of individuals with

psychiatric disorders; increased self-esteem, reduced negative symptomology, reduced psychiatric hospitalization, reduced recidivism and involvement in the justice system, and increase life satisfaction. Unemployment and poverty are very traumatic for every resident of Washington State. People who remain in poverty are at a higher risk for physical and behavioral health conditions, as well as substance use related disorders. Results from regressions on earnings suggest that Healthcare for Workers with Disabilities (HWD) participants with prior Medicaid coverage earn substantially more than non-participants in the year following enrollment. On average, they earn roughly \$2,000 more than their contemporary peers in the following year and \$2,500 more than a historical comparison group. Healthcare for Workers with Disabilities (HWD) Participants historically rely less on Basic Food benefits.

Healthcare for Workers with Disabilities (HWD) will create and sustain a culture of respect, caring and inclusion through employment. Programs that focus on employment enhance the value and respect garnered by the individual and help them to sustain their culture in the community. It empowers them to become positive role models. Services provided are inclusive of all who need them and targeted to individuals with a range of disabilities that have become successfully employed. Outreach will address the foregoing population.

Project #: BGCE-RSS35

Project Title: Implicit Biased Training for Landlords

Proposed Budget: \$10,000

*Additional \$10,000 SABG

Scope:

This project would create a training series for landlords on Implicit Bias. Implicit bias describes our attitudes towards people or associates stereotypes with them without our conscious knowledge. Implicit Bias trainings are designed to exposed to people to their biases and provide tools to adjust automatic patterns of thinking and ultimate eliminate discriminatory behaviors.

The Division of Behavioral Health and Recovery would work in partnership with the Department of Commerce's Landlord Mitigation Project to provide training to landlords who often rent to individuals with behavioral health conditions. Training would focus on addressing and identifying implicit biases and how this could be unintendedly affecting their decision on who to rent to.

This project is important because Washington State has a serious deficit of safe and affordable housing. This means that rentals are extremely scarce, and landlords could unintendedly discriminate against people of color and people with behavioral health conditions. The anticipated outcome of this project is to help landlords identify and then address their implicit biases.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal court interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

A disproportionate number of individuals of color experience housing instability. Many of these individuals experience significant barriers in accessing safe and affordable housing. WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. People with trauma, a history of homelessness, and co-occurring disorders have an increased likelihood of being involved in the criminal court system. This training will educate landlords on how their implicit bias might limit who they choose to rent to.

Project #: BGCE-RSS36

Proposed Budget: \$500,000

Project Title: Funding for SSI/SSDI, Outreach, Access, and Recovery (SOAR) Leads

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance.

Scope:

SSI/SSDI Outreach Access and Recovery (SOAR) is a proven effective model to increase access to governmental benefits. This project would create a SOAR Lead Position in multiple regions/counties (scalable). SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads hold local steering committee meetings, lead SSI/SSDI, Outreach, Access and Recovery (SOAR) online course training cohorts and conduct half-day SSI/SSDI, Outreach, Access and Recovery (SOAR) online course review sessions. SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads will also be mentoring individuals who complete the SSI/SSDI, Outreach, Access and Recovery (SOAR) online course and reporting on outcomes.

This will provide increased access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a serious mental illness. Access to these benefits will help individuals stabilize their housing and health.

Addressing State Needs and Gaps, Including Gaps in Equity:

Many unhoused individuals qualify for disability benefits but have a difficult time getting through the application process. With an SSI/SSDI, Outreach, Access Recovery (SOAR) Representative assisting with the application process, individuals are approved more often and more quickly. Most landlords require some kind of monthly income, this will help provide that and allow more individuals to obtain housing.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity

through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS41

Project Title: Enhance Mobile Crisis Teams with CPCs

Proposed Budget: \$1,909,000

Scope:

HCA will build upon the Transformation Transfer Initiative (TTI) crisis services continuing education curriculum for Certified Peer Counselors by piloting enhancements to mobile crisis teams by adding Certified Peer Counselors to existing teams. Funds will be issued to BH-ASOs to expand Mobile Crisis Response services serving those diagnosed with SMI/SED.

This project will provide enhance mobile crisis services by adding certified peer counselors in Washington State. The intended outcome is to increase the engagement and outreach of MCR teams to include certified peer counselors to even more effectively support the peers they serve in crisis settings.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. Expanding mobile crisis services to include Certified Peer Counselors will better support people as Washington expands peer services in crisis settings.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote DEI and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Tribal Projects Detail

Project #: BGCE-TRB3

Project Title: Funding to Tribes and Urban Indian Health Organizations

Proposed Budget: \$861,000

*Additional \$1,270,794 SABG

Waiver Provision(s)/SAMHSA Recommendation(s) Utilized:

- Operation of an “access line,” “crisis phone line,” or “warm lines” to address any

mental health issues for individuals.

- Training of staff and equipment that supports enhanced mental health crisis response and services.
- Mental Health Awareness training for first responders and others.
- Hire of outreach and peer support workers for regular check-ins for people with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).
- Prison and jail re-entry and enhanced discharge from inpatient settings in order to reduce risks of COVID-19 transmission.
- COVID-19 related expenses for those with Serious Mental Illness/Serious Emotional Disturbance (SMI/SED), including testing and administering COVID vaccines, COVID awareness education, and purchase of Personal Protective Equipment (PPE)

Scope:

The Health Care Authority will provide contracts to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver needed mental health services to adults and youth with SMI/SED to prevent, prepare for and respond to behavioral health gaps due to COVID within their Tribal communities. Tribes would submit a plan to implement recommended services as outlined in the NOA and allowed within the Mental Health Block Grant (MHBG) regulations. Additional Funds to Tribes \$40,993 SABG per Tribe and \$27,778 MHBG per Tribe, totaling \$68,771 for each Tribe.

This project is important because American Indian/Alaskan Native (AI/AN) and Tribal communities have been greatly affected by the COVID pandemic and the various Tribal and State Stay at Home Orders. Tribes are navigating how to operate Behavioral Health program in a virtual and semi/virtual environment. Due to the pandemic, Tribes are stating that the individuals in their communities are struggling with social isolation and a lack of treatment services due to the pandemic. There has also been limited cultural activities available for Tribal communities due to the pandemic. The historic annual Canoe Journey was canceled two years in a row with very limited ability to implement cultural programs across all Tribal communities.

Addressing State Needs and Gaps, Including Gaps in Equity:

Department of Health (DOH) reported that overdose rates have gone up over 154% during the first 6 months of the pandemic and is the highest of other communities by race/ethnicity. The statewide increase overall is 30%. The Health Care Authority needs to continue to provide resources to Tribal communities to address those diagnosed with SMI or SED for American Indian/Alaskan Native (AI/AN) in WA. Providing direct funding to Tribes and Urban Indian Health Programs (UIHPs) also honors our government-to-government relationships by partnering with Tribes to serve American Indian/Alaskan Native WA State residents.

This project directly supports Diversity, Equity and Inclusion (DEI) by providing needed services to the American Indian/Alaskan Native (AI/AN) population in providing culturally appropriate services. This also honors our unique Government-to-Government (G2G) relationships with Tribal governments and our partnership with Urban Indian Health Programs (UIHPs).

Crisis Services:

Tribes and Urban Indian Health Programs (UIHPs) may provide crisis services with these funds. The Health Care Authority will pass down National Guidelines to Tribes to provide guidance on best practices for crisis services.

Project #: BGCE-TRB4

Project Title: Traditional Healing Pilot Project

Proposed Budget: \$100,000

*Additional \$100,000 SABG

Scope:

The Health Care Authority will contract with the Seattle Indian Health Board (SIHB) to (1) document best practices (including practice and administrative tools) for an Indian Health Care Provider (IHCP) to offer traditional healing/traditional Indian medicine (TIM) services, and (2) analyze the health outcomes and potential cost savings from offering Traditional Indian Medicine (TIM) services. TIM can serve individuals with SMI/SED and substances use disorder, alongside Western based strategies for the prevention, treatment, and recovery of SMI/SED/SUD. TIM can also help with SMI/SED/SUD prevention. The services may include storytelling, talking circles, drumming, sweat lodge, prayers, blessings (such as cleansing and smudging), etc. TIM services are provided by a community-verified practitioner of TIM. Please note that this grant will not pay for actual TIM services. The Seattle Indian Health Board (SIHB) deliver the following to the Health Care Authority:

1. Recommendations for billing, coding and reimbursement models for Traditional Indian Medicine (TIM) services.
2. Analysis, recommendations, and examples of charting for Traditional Indian Medicine (TIM) services and incorporation of charting into an Electronic Health Record (EHR).
3. Recommendations and analysis on best practices for incorporating Traditional Indian Medicine (TIM) practitioners into integrated care teams.
4. Recommendation and analysis for privileging and credentialing standards of Traditional Indian Medicine (TIM) practitioners and apprentices.
5. Evaluation and analysis of the health outcomes for individuals and populations receiving the Traditional Indian Medicine (TIM) services. Measures could include:
 - Number of services completed;
 - Impacts on health outcomes;
 - Policy analysis;
 - Estimated costs of encounters;
 - Cost benefit analysis;
 - Comparison of the population that receives Traditional Indian Medicine (TIM) and the population that does not;
 - Comparison of patient's perception of their health pre-Traditional Indian Medicine (TIM) services and post-Traditional Indian Medicine (TIM) services, etc.

These items will be submitted as separate reports and guidance documents that will be available for the Health Care Authority, federal partners and other Indian Health Care Providers and Tribes in providing technical assistance on integrating Traditional Indian Medicine (TIM) into health programs with a focus on the treatment and recovery of Serious Mental Illness/Serious Emotional Disturbance (SMI/SED).

The Washington Indian Health Care Improvement Act, passed by the state legislature in 2019, had three main goals:

1. Provide resources to ensure the highest possible health status of American Indians/Alaska Natives (AI/AN) in Washington;
2. Raise the health status of American Indian/Alaskan Native (AI/AN); and
3. Ensure tribal self-determination in the areas of health care services.

One recommendation coming out of the Act was the expansion of traditional Indian medicine (TIM). This project helps the Health Care Authority to honor this key recommendation. Traditional Indian Medicine (TIM) services provide unparalleled support for American Indian/Alaskan Natives individuals struggling with severe mental illness or severe emotional disturbances and Western medicine has proven to not be appropriate for treatment and recovery supports for these American Indian/Alaskan Native (AI/AN) individuals. The anticipated outcome is documentation of positive health outcomes for individuals receiving Traditional Indian Medicine (TIM) and guidance to other Indian Health Care Providers (IHCP) on how to incorporate Traditional Indian Medicine (TIM). If not approved, we will continue to have a lack of literature available to demonstrate positive health outcomes or cost saving of these services for American Indian/Alaskan Native (AI/AN) and therefore, continue to struggle in finding sustainable funding.

Addressing State Needs and Gaps, Including Gaps in Equity:

The WA State Department of Health has found that American Indian/Alaska Native (AI/AN) overdose fatality rates have gone up 154% during the COVID pandemic. There is a known gap in the provision of culturally appropriate services for American Indian/Alaskan Natives (AI/AN) in the state of Washington and at a national level. Tribes and Indian Health Care Providers (IHCPs) are the experts in providing culturally appropriate services; however, Traditional Indian Medicine (TIM) does not have a sustainable funding mechanism. There are many evidence-based practices (EBP) available for Mental Health services; however, there are limited studies with American Indian/Alaskan Natives (AI/AN). Tribes and Indian Health Care Providers (IHCPs) find that implementing Evidence-Based Programs do not always work for American Indian/Alaskan Native (AI/AN) individuals and Tribal communities. This project will seek to develop evidence related to the efficacy of Traditional Indian Medicine (TIM) services for American Indian/Alaskan Natives (AI/AN) suffering from severe emotional disturbance or severe mental illness.

This project directly addresses Diversity, Equity and Inclusion (DEI) principles by providing support for Traditional Indian Medicine (TIM) and integration with clinically based health care. For decades, the response to Traditional Indian Medicine (TIM) is there is a lack of clinical data associating Traditional Indian Medicine (TIM) with better health outcomes. This pilot project will provide guidance around integration of Traditional Indian Medicine (TIM) and clinically based primary care and preliminary data to build the case for Traditional Indian Medicine (TIM). The intent is to provide foundational research and evidence that will support a request for sustainable Medicaid reimbursement for Traditional Indian Medicine (TIM).

Crisis Set-Aside Projects Detail

Project #: BGCE-ASO2

Proposed Budget: \$1,346,000

Project Title: Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding for Crisis Services

Scope:

Funding directed to the Behavioral Health Administrative Service Organizations (BH-ASO's) will support their respective provider networks enhancing the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. Funding will be used to enhance existing Crisis Services provided 24 hours a day, seven days a week including crisis call line, evaluation and treatment services for Individual's ineligible for Medicaid, including involuntary inpatient services, voluntary inpatient services, crisis stabilization services, Employment and Training (E&T) services, and services for the priority populations defined per Contract. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retention issues that have increased throughout the behavioral health delivery system during the pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that

policies and procedures have had different negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation. Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based mental health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health and substance use crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments; and strategies to reduce the fragmentation of mental health care.

Washington

American Rescue Plan Act Funding Work Plan for FY22-25

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

Center for Mental Health Services
Division of State and Community Systems Development

Mental Health Block Grant APRA Funding Plan

WA State Summary

The COVID-19 pandemic has had a significant impact on people with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) in Washington State. During the first half of 2019, 8.2% of adults over 18 years of age had symptoms of anxiety disorder and 6.6% had symptoms of depressive disorder. By comparison, in the most recent Household Pulse Survey from the Centers for Disease Control examining trends from February 17, 2021, to March 1, 2021, this prevalence quadrupled to 33.4% for anxiety and 27.7% for depression (in Washington state, rates were slightly higher with 34.2% for anxiety, 14th highest of the 50 states, and 27.8% for depression, 23rd highest of the 50 states). The age group with the highest prevalence rates nationally is 18–29-year-olds (47.2% reporting anxiety, and 42.2% reporting depression). The devastating impacts of the COVID-19 pandemic have clearly impacted young adults' mental health and substance use (a population already at high risk).

As the state and nation emerge from early Phases of the pandemic, the resulting impacts of the last year are a salient concern. People face potentially new obstacles such as continued mental health issues, overcoming the potential disruptions in school, work, and finances, and re-engaging in social life with continued recommendations from the CDC and local health departments (e.g., mask mandates). This is a critical time to address potential harms and to encourage engagement in both adaptive coping behaviors and unique strategies of social engagement within current public health guidelines to reduce high-risk substance use and worsening mental health symptoms, in both adults and youth.

HCA's Division of Behavioral Health and Recovery has reviewed the *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* and allocated a percentage of the total potential American Rescue Plan Act (ARPA) funding to address principles focused on recovery needs, support for the behavioral health workforce, particularly of Peers and Recovery Support Peers, and trauma-informed treatment services. Our intention is to use the ARPA funding to sustain projects originally funded through the Covid Supplemental award through September 2025, which will result in some of our contracts not being executed until March 2023. In addition to extending support for those projects, we are also adding in new funding for suicide prevention and technology infrastructure. The budget summary, on the following pages, provides the detailed amounts allocated across the continuum of behavioral health services through a wide variety of projects, treatment funds provided through our Behavioral Health Administrative Service Organizations (BH-ASOs) and Tribes. The Washington Health Care Authority respectfully submits the proposals you will find in the pages to follow.

As part of our effort to seek stakeholder input, the Behavioral Health Advisory Council co-hosted a meeting with the Health Care Authority to invite input from various partners and representatives from across the state's behavioral health system (from Peers to school districts, as well as counties, managed care organizations and others) on priorities for the Covid-19 Supplemental funding. Input on the proposals was received at the end of the event, which helped to inform the direction, as well as solidify the allocations to each section. We are utilizing the input received from this to guide us in our investments using the ARPA funding as well. The Health Care Authority may also require some flexibility to move allocations from one proposal, to another, within those in this application, in the event a

particular proposal is particularly successful and requires funding allocation from another proposal which may not require the entire allocation presented in this application. Additionally, the Washington Legislature will require the review and approval of our workplan in the 2023 Legislative session, which may create the need to shift funding based on their decisions at that time.

Within the budget summary below, you will find the proposed project titles, a brief description and number for each project under the sections of Prevention, First Episode Psychosis, Treatment, Recovery Support Services, Tribal, Crisis Services and Technology Infrastructure. In the pages that follow, a longer project narrative will include the project title, budgeted amount, a description, or scope of work summary, as well as a narrative of how the project addresses state needs and gaps, especially gaps in equity.

WA is grateful to SAMHSA for the opportunity to apply for the ARPA funds, as this has been an unprecedented year of extreme stressors to the most vulnerable among us, and the funding will undoubtedly support those persons at greatest risk, as well as those who seek support in treatment and ongoing recovery.

Project List and Budget Table

Prevention			
Project #	Project Title	Project Description	Proposed Budget
MHAR-Px1	Suicide Prevention	Develop and expand programming for new and continuing community-based organizations with a specific focus on suicide prevention in high-need communities.	\$1,660,114
Total Prevention Set-Aside			\$1,660,114
FEP Set-Aside			
Project #	Project Title	Project Description	Proposed Budget
MHAR-CYF1	Rural and AI/AN Evidence Based Coordinated Specialty Care for FEP	Develop and adapt evidence based coordinated specialty care programs for FEP to meet the needs of rural, frontier and AI/AN communities.	\$3,984,273
Total FEP Set-Aside			\$3,984,273
Treatment			
Children, Youth and Family Treatment Funding			
Project #	Project Title	Project Description	Proposed Budget

MHAR-CYF2	Developing Wraparound and Intensive Services (WiSe) Workforce Support	Developing Wraparound and Intensive Service (WiSe) workforce to support youth with Intellectual Disabilities/Developmental Disabilities (including Autism Spectrum Disorder (ASD)).	\$600,000
MHAR-CYF5	Trauma Focused Cognitive Behavioral Therapy Training	Trauma Focused Cognitive Behavioral Therapy (CBT) Training for clinicians serving children and youth returning to school as part of the triage process post screening.	\$376,671
Adult Treatment Funding			
MHAR-MHA1	Cognitive Behavioral Therapy for Psychosis	Expansion of current contract to deliver Cognitive Behavioral Therapy for Psychosis to a cohort of clinicians who are serving people on 90/180 involuntary civil commitment orders.	\$130,000
MHAR-MHA3	Mental Health Specialist Training	Provide training via a 100-hour course for Mental Health (MH) professionals to secure credentials to become an Older Adult Mental Health Specialist, Intellectual Disabilities /Developmental Disabilities (ID/DD) Mental Health Specialist, and Ethnic Minority Mental Health Specialist.	\$396,671
BH-ASO Treatment Funding			
MHAR-ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding	The community mental health services provided include but are not limited to outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, residents of the service areas who have been discharged from inpatient treatment at a mental health facility, day treatment or other partial hospitalization services, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, or ready for discharge from inpatient psychiatric care, and individuals residing in rural areas.	\$10,066,183
Total Treatment			\$11,569,525
Recovery Support Services			

Project #	Project Title	Project Description	Proposed Budget
MHAR-RSS1	Participant Support Funds-Housing and Recovery through Peer Services (HARPS) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$50,000
MHAR-RSS2	Participant Support Funds-Projects for Assistance in Transition from Homelessness (PATH) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$140,000
MHAR-RSS3	Participant support Funds - Peer Bridger	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$100,000
MHAR-RSS12	Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams	Targeted peer outreach on Project for Assistance in Transition from Homelessness (PATH) teams focusing on a by-name list of individuals who have had multiple contacts with crisis system.	\$1,759,433
MHAR-RSS14	Operating costs for a housing inventory/estimator/calculator	Provide timely information for individuals with behavioral health conditions to access housing services and resources.	\$10,000
MHAR-RSS16	Supportive Housing Institute	Corporation for Supportive Housing (CSH) curriculum to increase the number of affordable housing development for individuals with mental health and substance use disorders.	\$150,000
MHAR-RSS19	Cover Foundational Community Support Services in Institution for Mental Disease (IMD) when Medicaid is Suspended	Utilize block grant funds that would cover Foundational Community Support services for people transitioning out of Institution for Mental Disease (IMD) settings if Medicaid does not get retroactively reconnected.	\$500,000

MHAR-RSS24	Peer Pathfinders Transition from Incarceration Pilot	Enhance jail transition programs with SUD peers services to individuals who upon release will be homeless. SUD Peer Services begin prior to release to establish relationship and upon release to support the transition to needed services.	\$790,000
MHAR-RSS25	Add Co-Occurring Peer to Forensic-Housing Housing and Recovery through Peer (F-HARPS) Services	Add 1 peer to each of the four Forensic-Housing Housing and Recovery through Peer Services (F-HARPS) in Phase I regions.	\$400,000
MHAR-RSS36	Funding for SSI/SSDI Outreach, Access, and Recovery (SOAR) Leads	Helping individuals with the creation of a Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) outreach access and recovery community coordinators.	\$500,000
MHAR-RSS41	Enhance Mobile Crisis Teams with CPCs	Pilot enhancements to mobile crisis teams by adding CPCs to existing teams.	\$1,909,000
Total Recovery Support Services			\$6,308,433
Tribal			
Project #	Project Title	Project Description	Proposed Budget
MHAR-TRB1	TARGET (database) Replacement	TARGET replacement program for SUD and mental health data.	\$200,000
MHAR-TRB3	Funding to Tribes and Urban Indian Health Organizations	Provide funding to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver treatment for individuals diagnosed with SMI/SED, prevention, treatment, and recovery support services within their Tribal communities.	\$1,460,114
Total Tribal			\$1,660,114
Crisis Set-Aside			
Project #	Project Title	Project Description	Proposed Budget
MHAR-ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding - Crisis Services	Services include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responders (DCR) services.	\$3,320,228

Total Crisis Set-Aside			\$3,320,228
Technology Infrastructure			
Project #	Project Title	Project Description	Proposed Budget
MHAR-TEC1	Clinical Data Repository	Support technological enhancements to the CDR that will allow retention of historical clinical data, including MH/SUD data, as well as implementation of an analytic enclave environment.	\$325,000
MHAR-TEC2	Consent Management Solution	Enable meaningful, seamless exchange of protected and sensitive BH and PH information amongst those who are authorized to receive it in order to deliver services to Washingtonians.	\$1,300,000
MHAR-TEC3	Statewide Bed Registry	Develop and implement a statewide bed registry to track capacity and real-time bed availability for psychiatric hospital beds, freestanding evaluation and treatment center beds, Secure Withdrawal Management and Stabilization Beds, crisis triage/stabilization beds, and substance use disorder residential treatment beds.	\$1,414,478
Total Technology Infrastructure			\$3,039,478
TOTAL MHBG Covid Supplement Budget			
Suicide Prevention			\$1,660,114
FEP Set-Aside			\$3,984,273
Treatment			\$11,569,525
Recovery Supports Services			\$6,308,433
Tribal			\$1,660,114
Crisis Set-Aside			\$3,320,228
Technology Infrastructure			\$3,039,478
Administrative			\$1,660,114
Total Budget			\$33,202,279

Prevention Project Detail

Project #: MHAR-Px1

Project Title: Suicide Prevention

Proposed Budget: \$1,660,114

Scope:

Washington State is facing an increased demand for suicide prevention services both before and in the face of the COVID-19 pandemic. To address the social and mental health needs of communities, the Washington Health Care Authority is requesting \$1,660,114 for 2022 through 2025 to implement and expand projects/programs in communities where there is a demonstrated need for suicide prevention. The requested funds represent costs associated with the performance and administration of suicide prevention projects to community-based organizations in the state. HCA suicide prevention projects are direct service evidence-based, promising, and evidence-informed strategies with a focus in high-need communities. These services ensure that WA State keeps pace with best practices and has current training in providing services. Suicide prevention services are crucial for all communities in Washington, but current funding levels limit the reach of state sponsored programming. Of the twenty-three community-based applicants requesting suicide prevention funding, only twelve organizations were awarded based on current state funding levels despite the record number of quality submissions for the RFA. This demonstrates a need for suicide prevention in the state that is not currently being met due to funding, not capacity, limitations.

The current proposal/project asks for funds to develop and expand programming for new and continuing community-based organizations with a specific focus on suicide prevention in high-need communities. The expanded programming will include:

- Evidence-based and promising programs identified on one or more evidence-based lists showing effectiveness for mental health and/or suicide prevention outcomes.
- Mental health First Aid and/or Youth Mental Health First Aid provided to individuals working in populations with individuals who may be experiencing suicidal ideation to recognize signs and connect individuals to resources.
- Youth and parent programs focused on reducing stigma and encouraging individuals to seek help.
- Information dissemination campaigns that target individuals at higher risk for death by suicide.
- Evaluation of programming to assess desired outcomes being met.
- Continued training and professional development opportunities for partners and coordinators of suicide prevention programming to ensure information sharing and implementation of best practices.

The global COVID-19 pandemic presents new and continued challenges in mental health promotion and suicide prevention in the State of Washington. Before the pandemic, the number of suicides in Washington State increased by 13 percent from 2016 to 2019, with a raw increase of 1123 deaths in 2016 to 1263 deaths in 2019 (WA DOH, 2020). According to preliminary data from the Washington Department of Health in December 2020, the ongoing pandemic has the potential to create a disaster

cascade, causing the risk of suicide, depression, hopelessness, and substance use to increase due to isolation, stress, and fear from the economic, physical, social consequences of the crisis. This is especially felt among specific high-risk groups who are unable to access healthcare or other necessary resources, like young adults, LGBTQ+, certain occupational groups, and persons who are undocumented. Youth data collected in Washington State during the pandemic reflect this. According to the COVID-19 Student Survey (CSS), 45 percent of middle school students and 58 percent of high school students that completed the survey reported feeling sad or depressed most days in the past 12 months, as compared to 32 percent of middle school students and 41 percent of high school students self-reported in the 2018 Health Youth Survey. (Note, while CSS and HYS are not directly comparable due to administration methods, it does provide context for comparison.) Though students reported higher rates of depression and sadness during the pandemic, around two thirds of respondents reported feeling hopeful about the future, demonstrating a social momentum that the State can capitalize on.

The anticipated outcomes of being able to fund suicide prevention efforts in high-need communities throughout the state of WA include decreased risk of suicide ideation and ultimately lower rates of death by suicide. By allowing communities to identify local solutions to local problems under a framework that has demonstrated outcomes, impacts are optimized, inclusion and cultural competency around local populations are respected, sustainability is integrated in the process, and lives are saved. Communities funded at current levels have seen a positive change with the implementation of evidence-based suicide prevention programming. Snohomish county, in western Washington, has experienced a statistically significant reduction in suicide attempts across all grades as a direct result of our previous MHPP funded suicide prevention efforts; the self-reported suicide attempt rate dropped from 17.1% of 10th graders in 2016, to just 6.7% in 2018, and when looking at the same graduating class of student from 2018, the self-reported suicide attempt rate dropped from 17.1% of 10th graders in 2016 to just 10.0% for that same graduating class as 12th graders in 2018 (HYS, 2002-2018). Without MHPP CBO funding, and other Districts around Washington State, are left without adequate Mental Health Promotion and Suicide Prevention funding.

C25	Monroe School District 10th Grade NO Adult to Turn Rates (HYS)							
2002	2004	2006	2008	2010	2012	2014	2016	2018
n/a	n/a	18.1%	19.9%	16.6%	15.3%	15.4%	13.7%	8.2%

H56	Monroe School District 10th Grade Attempted Suicide Rates (HYS)							
2002	2004	2006	2008	2010	2012	2014	2016	2018
9.8%	8.6%	5.6%	12.3%	9.8%	8.3%	8.0%	17.1%	6.7%

With additional funding we will be able to support additional communities like Snohomish County and short-term outcomes that include a decrease in youth reporting symptoms of depression, anxiety, and suicidal ideation as reported on our WA State Healthy Youth Survey. Longer term impacts include decreased suicide ideation, attempts, and deaths across the WA populace. Without these pointed efforts that are developed, implemented, and owned by the community, there is an increased likelihood that outside efforts will not align with local readiness, cultural nuances, and, in the end, lack sustainability. This ultimately leads to a lower quality of life for Washingtonians and preventable death.

Addressing State Needs and Gaps, Including Gaps in Equity:

The success in Snohomish County illustrates the impact of community driven solutions on the rate of suicide among high-risk groups. But despite these accomplishments, the rate of suicide in Washington State is still higher than the national average. The suicide rate in Washington has increased from 13.8 percent in 2010 to 16.2 percent in 2019, compared to the national suicide rate which increased from 12.4 to 14.8 over the same time. For Washington State, that equates to 11,160 lives lost due to suicide from 2010 to 2019, and countless other family and community members lives affected after suicide (WA DOH, 2020). According to the state Suicide Prevention Plan, an average of 65 people in Washington each week are hospitalized due to intentional self-inflicted injuries. The Centers for Disease Control estimates that suicide and suicide attempts cost society about \$70 billion a year nationally in combined medical and work loss costs.

As the state and nation transition to a different phase of the pandemic, high risk individuals like young adults, face potentially new obstacles such as continued mental health issues, overcoming the potential disruptions in school, work, and finances, and re-engaging in social life with continued recommendations from the CDC and local health departments (e.g., mask mandates). There is a critical need for suicide prevention outreach and programs. This is a critical time to address potential harms and to encourage engagement in both adaptive coping behaviors and unique strategies of social engagement within current public health guidelines to reduce high-risk substance use and worsening mental health symptoms.

We know that suicide impacts different populations in WA disproportionately. LGBTQ youth in particular. While some of this is attributed to factors such as access to lethal means and distance from medical facilities, some is attributable to social determinants of health and other factors that are nuanced within community. By utilizing a framework, the focuses on community identified and implemented solutions, and ensuring that this framework considers local conditions and factors, optimized outcomes become much more likely. This is particularly true when the application of the framework is inclusive of data and engagement of the target population in the process.

Current funding is insufficient to meet demand for suicide prevention and crisis intervention. This is a significant public health issue as WA State's suicide rate continues to increase. WA needs funding for adequate services in suicide prevention, intervention, treatment, and post-vention (resource provided in the aftermath of suicide) so we can support individuals, families, and communities affected by suicide deaths.

The CDC Household Pulse survey from late February 2021, symptoms of anxiety disorder were reported by a greater percentage of participants who identified as non-Hispanic, other races and multiple races (42.8%), Hispanic or Latino (36.9%), or non-Hispanic, black, single race (35.5%) than those who identified as non-Hispanic white, single race (32.1%). According to the Washington Department of Health, 2020 compared to 2019 saw an increase in suicides among person who identify as Hispanic (WA DOH, 2020).

With evidence suggesting disproportionate impact of the COVID-19 pandemic on communities of color, and with other evidence suggesting less help-seeking and/or utilization of counseling or services requiring interaction with others (both within the 18–29-year-old age group and within select racial/ethnic groups), programming that supports suicide prevention for these high-risk groups is desperately needed.

First Episode Psychosis Project Detail

Project #: MHAR-CYF1

Project Title: Rural and AI/AN Evidence Based Coordinated Specialty Care for FEP

Proposed Budget: \$3,984,273

Scope:

This additional project amount would be to develop and adapt evidence based coordinated specialty care (CSC) programs for first episode psychosis (FEP) to meet the needs of rural, frontier, AI/AN communities, and other special populations; with the necessary support to operationalize the projects in a timely manner. The project would be to help to develop a rural and /or Tribal New Journeys/CSC model, to evaluate it, and broadly disseminate the results to inform future program development. This model can expand to other specific populations as the work advances. Other states are also interested in figuring out how to develop CSC services in rural areas and Tribal communities and other specific populations. There could be great value in collaborating with partners in other states on this (they would fund their own program development) and could help to define rural and AI/AN CSC in other parts of the U.S.

This work is critical to accomplish the legislative mandate in SSSB 5903 requiring statewide expansion of treatment for FEP. Specialized knowledge and adaptation are essential to meet the unique needs of sparsely populated regions and minority communities in order to achieve the goal of decreasing the duration of untreated psychosis. Considering the magnitude of the impact of schizophrenia, interventions designed to treat the disorder effectively at the earliest possible point (e.g., during the first episode of psychosis) have the potential to improve its long-term trajectory, improve outcomes, improve lives, save lives and save health care dollars and to reduce the health care burden of the illness. The longer a person goes untreated, the more severe and chronic their symptoms become, often resulting in decreased functioning and other negative outcomes over their lifetime.

Addressing State Needs and Gaps, Including Gaps in Equity:

Initial examination of 2018 Medicaid data indicate that extra support is needed to ensure that intervention with first episode is equally available in rural geographical areas and in AI/AN communities. The data suggest there are existing geographical disparities and AI/AN disproportionality. The Washington State Legislature, Children's & Youth Behavioral Health work group (CYBWHG) and SAMSHA have all prioritized early identification and intervention for psychosis. This is so screening and early identification of psychosis among adolescents and young adults will become a universal health care practice, and evidence-based recovery interventions will be available to those who need them.

Treatment Projects Detail

Children, Youth and Family

Project #: MHAR-CYF2

Project Title: Developing Wraparound and Intensive Services (WiSe) Workforce Support

Proposed Budget: \$600,000

Scope:

Expansion of Workforce & Enhancing Local Care Networks to support Youth with Intellectual or Developmental Disabilities including Autism Spectrum Disorder.

Based on the initial model, identify additional WiSe behavioral health agencies each year to plan and implement the project informed by local needs with logistical oversight provided the WiSe Workforce Collaborative/En Route. Develop glide path for more expansive reach of focused special population services. A training component will be provided by Seattle Children's Autism Center and offered to additional BH agencies. The proposed RUBI training model will include:

- (1) An initial 16-hour workshop attended by all WiSe team providers;
- (2) 20 weeks of ongoing consultation with the WiSe team mental health therapist
- (3) Fidelity review of WiSe therapist implementation of RUBI sessions

Agencies selected will have been involved in the HCA and DDA convened WiSe and ID/DD and ASD workgroup or Project Echo sessions. This allows the project to build more directly on the knowledge and efforts already in process.

The three lead agencies will dedicate a portion of a staff time to participate in developing the specialty team model, attend training, learning collaboratives and consultation. Lead sites will also convene community partners to plan for enhancing their local care network to support youth with ID/DD and ASD.

During COVID the increased need of trained staff to provide stabilization support for youth in WiSe with ID/DD including ASD has become apparent. The concern identifying the need for additional training has been expressed by caregivers, behavioral health agency staff and allied system partners. Our behavioral health workforce is often times generalists by education and don't have the training to best support youth with ASD and their families. This funding would provide the training support and consultation to

five behavioral health agencies as well as enhance community coordination in three regions for youth enrolled in WISe with ID/DD including ASD.

Addressing State Needs and Gaps, Including Gaps in Equity:

Provides workforce training and development to address the need in providing co-occurring services for youth with ID/DD including ASD. Also provides funding for community coordination and input from youth, families and system partners.

The community coordination and development of this project would include outreach to BIPOC communities to participate and provide insight to specific community needs.

Project #: MHAR-CYF5

Project Title: Trauma Focused Cognitive Behavioral Therapy Training **Proposed Budget:** \$376,671

Scope:

Continue to provide training in TF-CBT to clinicians serving children and youth returning to school as part of the triage process post screening as a part of the recommended DOH fast response plan to help meet the needs of children and youth returning to school following the Governor's proclamation that in person options are required as of April 1, 2021. This will allow clinicians to continue to serve youth who indicate trauma exposure in the screening process (SED) following the pandemic to support increased access to necessary mental health supports. This will advance the Sonoma model and further enhance the clinical interventions available to children and youth across WA.

The Governor issued a proclamation that in person options be available across WA as of April 1, 2021. The potentially unmet needs of children and youth throughout the pandemic regarding mental health impact are expected to surface as children youth and families begin the transition to in person education. This proposal meets an identified need, and the timeline will ensure that trauma informed clinical interventions will be available to children and youth as transition back to school and acclimate to new norms.

Addressing State Needs and Gaps, Including Gaps in Equity:

The workforce serving children youth and families across Washington are dedicated to the age group and the developmentally appropriate interventions needed. This training further supports them in an evidence-based response to the expected wave of trauma exposure from impacts of the pandemic, to support and serve with resilience and strength based approaches and supports in pushing back compassion fatigue in ensuring they have the tools they need to feel effective in their work, resulting in resilient communities.

Efforts will be made to ensure training is offered to diverse clinician groups including BIPOC and LGBTQ+ clinician groups.

Adult Treatment

Project #: MHAR-MHA1

Project Title: Cognitive Behavioral Therapy for Psychosis

Proposed Budget: \$130,000

Scope:

This project will continue to enhance the workforce serving individuals with psychosis by delivering Cognitive Behavioral Therapy for Psychosis training and technical assistance to a cohort of outpatient and inpatient clinicians from selected contracted community-based sites who are serving people receiving 90/180-day involuntary civil commitment orders. This EBP helps people living with psychosis achieve a level of self-management that has shown great success, supporting individuals and their families in the community.

Training outpatient behavioral health agency staff and their locally corresponding contracted long term civil commitment sites in an appropriate EBP should assist this population in better managing their symptoms and reduce their need for further involuntary or inpatient treatment.

Addressing State Needs and Gaps, Including Gaps in Equity:

Training on CBT for Psychosis will help empower individuals with psychosis to better manage symptoms that interfere with their ability to live their lives in the community. The BH workforce needs enhanced tools to treat psychosis beyond simply medication alone and this EBP is targeted to the needs of a population that traditionally does not receive therapy as many clinicians do not know about CBT for Psychosis and its success rate.

People living with psychosis experience much social isolation due to their symptoms. By providing them with greater skills to manage psychosis, this inequity will be better addressed. This enhancement will serve all populations living with psychosis, including members of BIPOC communities but is not a targeted outreach to them specifically.

Project #: MHAR-MHA3

Project Title: Mental Health Specialist Training

Proposed Budget: \$396,671

Scope:

Provide training via a 100-hour course for Mental Health Professionals to secure credential to become an Older Adult MH Specialist, Intellectual/Developmental Disabilities Mental Health Specialist, and Ethnic Minority Mental Health Specialist as defined in Washington's Rehab State Plan for Mental Health Outpatient treatment. Training curricula will focus on recognizing unique needs of these populations, clinical best practices, understanding of the community resources and partners when working with these populations, the role of the Mental Health Specialist, and how to provide clinical consultation, cultural humility, and other relevant information specific to each demographic.

The Division of Behavioral Health and Recovery has not sponsored MH Specialist academies for almost 10 years and as such, there are significant workforce shortages in specialists trained and credentialed to work with these populations. Each has their own unique needs or considerations that impact care and the BH workforce needs additional training and support in order to meet these needs.

Addressing State Needs and Gaps, Including Gaps in Equity:

With a fast-growing aging population, the need for MHPs trained and sufficiently skilled to work with older adults is more critical than ever. The current workforce requires specialized skills and knowledge to better support BIPOC populations and people with intellectual or developmental disabilities. This workforce shortage must be addressed.

BIPOC communities, older adults, and people with Intellectual Disabilities/Developmental Disabilities must receive culturally appropriate services from clinicians with relevant education, experience, and skills. This is a matter of equity and parity.

BH-ASO Treatment Funding

Project #: MHAR-ASO2

Project Title: Behavioral Health Administrative Services Organization (BH-ASO) Treatment Funding

Proposed Budget: \$10,066,183

Scope:

Funding directed to the Behavioral Health Administrative Services Organizations (BH-ASO) will support their respective provider networks enhancing the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. This includes a regionally based system of care that includes mental health services to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities. Including increasing capacity of Designated Crisis Responder (DCR) and Tribal Designated Crisis Responder (DCR) services.

The community mental health services are provided to individuals with serious mental illness/serious emotional disturbance including specialized outpatient services for American Indian/Alaskan Native (AI/AN), children, and the elderly. Services provided include but are not limited to outpatient services for individuals who have been **discharged** from inpatient treatment, day treatment, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, and individuals residing in rural areas. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental

health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retainment issues that have increased throughout the behavioral health delivery system during the pandemic.

If funding were not approved the statewide behavioral health service delivery system will continue to face funding gaps, service delivery delays, and individuals diagnosed with Serious Mental Illness (SMI), or Serious Emotional Disturbance (SED) will be less likely to have opportunities to access services and function better in their communities experiencing an improved quality of life. Further, an opportunity to enhance and improve ongoing behavioral health system workforce recruitment and staff retention worsened by the pandemic will be missed.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support, and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that policies and procedures have had negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation.

Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based behavioral health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments.

Recovery Support Services Projects Detail

Project #: MHAR-RSS1

Project Title: Participant Support Funds – Housing and Recovery through Peer Services (HARPS) Teams

Proposed Budget: \$50,000

Scope:

Adding additional support funds to each Housing and Recovery through Peer Support (HARPS contract to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination of other healthcare services and case management.

We expect the housing crisis and behavioral health crisis to intensify as eviction protections are lifted. The HARPS priority population is unable to earn wages while involved with inpatient treatment and is unlikely to have savings to secure housing upon discharge. Additionally, many participate intensive outpatient treatment which limits the amount of time to earn wages to afford housing, as well as other necessities to stay engaged in treatment and recovery activities.

Adding additional support funds to each Housing and Recovery through Peer Services (HARPS) contract to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination of other healthcare services and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Participant Support Funds will help the Housing and Recovery through Peer Support (HARPS) Teams to interweave care coordination, case management, and outreach services. People experiencing homelessness and behavioral health conditions benefit from connections to peer services and resources.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: MHAR-RSS2

Project Title: Participant Support Funds – Projects for Assistance in Transition from Homelessness (PATH) Teams

Proposed Budget: \$140,000

Scope:

Proposed support service funds will be added to the current contracted programs, Projects for Assistance in Transition from Homelessness (PATH). PATH programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency will be required to develop a detailed plan describing method and intended outcome for allocating client support service funding and submit to the Health Care Authority for approval by 09/30/2021. Plan must be based on Mental Health Block Grant (MHBG) guidance for Target Population* and Statement of Work.

Persistent and consistent outreach and providing services at the individual's pace are important steps to engage people with serious mental illness who are homeless. The proposed support service funds will enhance the quality of program delivery and engagement and expand critical client resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

Homeless outreach services intention is to reach individuals who are not currently engaged in services and potentially unable to navigate the system. The ability to have support services that offer basic needs upon engagement increases the likelihood for engagement in treatment and recovery.

PATH teams serve individuals experiencing homelessness and Serious Mental Illness (SMI) to BIPOC communities. BIPOC communities are overrepresented in homelessness. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: BGCE-RSS3

Project Title: Participant Support Funds – Peer Bridger

Proposed Budget: \$100,000

Scope:

The goal of this project is to use participant funds to connect people to community supports and treatment and reduce recidivism to the state hospital admissions. Keeping individuals engaged in peer services creates personal connection, accountability, and someone to assist in navigating complicated systems. Without these added supports the system continues to be a revolving door for many.

MHBG Funds could be used to support case managers, outreach workers, Assertive Community Treatment Services For people experiencing homelessness, medications, coordination with primary care, and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support improves engagement and increases hope by modeling recovery. These complimentary services will enhance the already proven Peer Bridger model.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: MHAR-RSS12

Project Title: Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams

Proposed Budget: \$1,759,433

Scope:

Proposed funds will continue funding for one peer counselor to the current Projects for Assistance in Transition from Homelessness (PATH). PATH programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency hired a peer counselor to expand outreach and engagement services for individuals with a serious mental illness (SMI) and homeless or at risk of homelessness utilizing the Block Grant Covid Supplemental funding, this will continue support for those positions through mid-2025. Projects will work closely with BHASO's, MCO's and Crisis stabilization centers to create a referral flow and coordination of services.

This continued support for a PATH peer counselor on the PATH teams will allow agencies to expand needed outreach and engagement efforts. The proposed funds will enhance the quality of program delivery and engagement and expand critical crisis resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

The intention of Homeless outreach services is to reach individuals who are not currently engaged in treatment, services and who are potentially unable to navigate the system. The ability to have one additional peer outreach team member will allow these programs to broaden the current outreach and engage services to a primary focus of crises response.

Projects for Assistance in Transition from Homelessness (PATH) teams currently serve individuals experiencing homelessness and mental illness and BIPOC communities. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: MHAR-RSS14

Project Title: Operating Costs for a Housing Inventory/Estimator/Calculator **Proposed Budget:** \$10,000

Scope:

The Research and Data Analysis Division (RDA) within the Department of Social and Health Services (DSHS) completed a series of reports in 2012 examining the housing status of individuals following their exit from institutional or out-of-home care settings. More than one-quarter of all five study populations (individuals leaving Substance Use Treatment Facilities; State Department of Corrections Facilities; Foster Care; State Mental Hospitals and Juvenile Rehabilitation Facilities) experienced homelessness at some point over a 12-month follow-up period. This funding supports the online searchable tool based on various scenarios to connect individuals with behavioral health conditions to housing.

This searchable tool that will be housed on the Research and Data Analysis Pathways to Housing site will be used to help address the fact that almost 50 percent of Individuals leaving residential substance use treatment facilities became homeless within the year of discharge. Individuals exiting prison, foster care, State Mental Hospitals, and Juvenile Rehabilitation facilities were more likely to experience homelessness but as likely to obtain to permanent housing when they received housing assistance. Across the five study populations, the proportion of individuals in need of housing who received Homeless Management Information System (HIMS)-recorded assistance was highest for youth aging out of foster care (at 35 percent). Even though this report is dated, it is believed these relate to the population we intend to start with: individuals with behavioral health issues still exist and may even be more exacerbated with the COVID pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will provide timely information for individuals with behavioral health conditions to access housing services and resources.

The searchable housing tool will ensure individuals with Behavioral Health conditions and part of the BIPOC population will have access to housing services and resources.

Project #: MHAR-RSS16

Project Title: Supportive Housing Institute

Proposed Budget: \$150,000

Scope:

DBHR proposes to use the proprietary curriculum from the Corporation for Supportive Housing to increase the number of affordable housing development for individuals with serious mental illness or serious emotional disturbance. HCA-DBHR will contract with CSH to assist with the design and implementation of two Supportive Housing Institutes (the "Institute") for the State of Washington whose completion will coincide with the capital and operating fund cycles of both 2022 and 2023. Each Institute will take place over a five-month period and allow for up to eight project teams per Institute.

Each team will be required to include a SUD/MH service provider, developer, and operator (property manager) of a specific, proposed project. CSH will lead the teams through hands-on learning to take their projects from concept to fully developed project plans. Each Institute will produce projects that are well prepared for state and local funding and that align with the national Dimensions of Quality Supportive Housing, which include and supersede the fidelity indexes of SAMHSA, Pathways, and Watson HRM.

The HCA oversees the State's Medicaid benefits called Foundational Community Supports, which include supportive housing and supported employment services. Providers State-wide are expanding their delivery of these services to beneficiaries who are experiencing chronic homelessness, unnecessary institutionalization, and cycles of homelessness and system involvement, but scaling supportive housing itself remains constrained by a lack of supportive housing apartments. The HCA aims to build the capacity of mental health and substance use treatment providers to develop, operate, and/or form strong partnerships with other organizations to deliver new, high-quality supportive housing developments.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal justice interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

Foundational Community Supports utilizes the evidence-based practices of SAMSHA's Permanent Supportive Housing and Westat's individual placement and support. The principles of these evidence-based practices encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. These services also value and approach participants with equity, respect as well as cultural humility with the hope of promising outcomes.

Project #: BGCE-RSS19

Project Title: Cover Foundational Community Support (FCS) Services in Institution of Mental Disease (IMD) When Medicaid is Suspended

Proposed Budget: \$500,000

Scope:

The Division of Behavioral Health and Recovery proposes to utilize block grant funds to cover Foundational Community Support services for people transitioning out of Institution of Mental Disease (IMD) settings if the Medicaid isn't retroactively reconnected. The Foundational Community Support (FCS) program assists eligible individuals with complex health needs obtain and maintain stable housing

and can provide Foundational Community Support services within short-term Institution of Mental Disease (IMD) settings with housing assessments and begin the housing acquisition process prior to discharge. These newly added services to Foundational Community Support will include coaching, advocacy, information and referral, linking and coordinating, and ongoing supports that they may not otherwise have access to.

The program offers an array of transition/pre-tenancy and tenancy-sustaining supports that have been effective in improving housing stability, health and employment outcomes for high need Medicaid beneficiaries. linking and coordinating, and ongoing supports that they may not otherwise have access to. Many of these individuals have complex health profiles and face multiple housing related barriers to effectively engaging with health care systems and managing their own plan of care to achieve improved health and wellness. Foundational Community Support have reduced the frequent use of emergency department and inpatient care, addressed significant gaps in connections to care, addressed homelessness, and now can help to facilitate timely, successful transitions from institutional settings to integration in community placements. Anticipated Outcomes:

- Effectively target interventions to eligible individuals in residential treatment settings;
- Streamline and standardize transition and tenancy-sustaining services for individuals exiting residential treatment across agencies and systems;
- optimize and braid all available funding to fill gaps;
- reduce Substance Use Disorder/Opioid Use Disorder (SUD/OD) related deaths;
- improve Substance Use Disorder system capacity; and
- improve quality of care

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is no other mechanism to reimburse Foundational Community Support providers if the individuals Medicaid is not active at the time of authorization. The Health Care Authority has taken steps to attempt to mitigate this by providing Foundational Community Support providers access to Provider One to check Medicaid eligibility. This however is not a perfect solution and there are times when Foundational Community Support providers go unpaid.

The Foundational Community Support program is based on the evidence-based practices (EBP) of Permanent Supportive Housing (PSH) and Individual Placement and Support (IPS). The principles of these Evidence-Based Practices encompass equity and racial justice through the promotion of choice, flexible voluntary services, and access.

Project #: BGCE-RSS24

Project Title: Peer Pathfinders Transition from Incarceration Pilot

Proposed Budget: \$790,000

Scope:

This funding will continue support for a Certified Peer Counselor to up to five existing BH-ASO contracts for jail transition services. Adding a Certified Peer Counselor to existing jail transition services teams will increase the level of services being provided, by having a CPC connect with the individuals while they are still in jail and helping them with transition to the community. The certified peer counselor will work

with individuals diagnosed with a serious mental illness, linking them to behavioral health services, including co-occurring treatment, Foundational Community Support (FCS), and other applicable services.

Multiple studies support the fact that Peer support services has significant impacts on quality of life, reducing substance use, and improving positive social supports. Studies have also identified common elements of peer support, suggesting possible processes that underlie effective peer support. Peer services include shared experiences, role modelling, and positive social support. All of which are suggested to be vital aspect of peer support and moderate positive life changes. By adding a certified peer counselor to existing Jail Transition services allows for access to these vital services for individuals with SMI and co-occurring health conditions, reducing likelihood for further court involvement. Impacts that are likely to occur if this project is not approved included recidivism because the individual was not provided the needed services during their jail transition.

Addressing State Needs and Gaps, Including Gaps in Equity:

People exiting jails are more likely to be successful when they are able to connect and engage in services in their communities upon release. Currently in some parts of the state jail transition services are only reaching jail populations a few times a month. By adding a Certified Peer Counselor to existing jail transition services, individuals who are in need of extra support in accessing community-based services can be offered the support of a peer. These certified peer counselors would focus on linking individuals to behavioral health services, including co-occurring treatment, housing and employment, and community resources.

A disproportionate number of individuals of color are represented in our criminal court system and they experience greater barriers in accessing healthcare and community behavioral healthcare. This problem is greater amplified the further away you move from urban settings and locations in which more services are available. By adding the support of a Certified Peer Counselor to existing jail transition services, this will increase the likelihood of individuals being able to overcome some of these barriers.

Project #: BGCE-RSS25

Project Title: Add Co-Occurring Peer to F-HARPS

Proposed Budget: \$400,000

Scope:

These additional funds would continue support for a certified peer counselor for each Forensic HARPS team in the phase 1 regions, originally funded through the Block Grant Covid Supplemental award. With this additional staff person, the teams would be able to increase caseload capacity. This position would also allow the Forensic HARPS teams to serve individuals diagnosed with serious mental illness or co-occurring.

This project is critical because it will increase the capacity of the teams to serve more eligible individuals through the Forensic HARPS program, an element of the Trueblood Settlement. Housing access, support, and short-term subsidies increase an individual's opportunity for recovery. Housing is a basic need that reduces the likelihood of recidivism in the criminal court system. If this funding is not approved, the Forensic HARPS teams will not be able to serve all those who are eligible and in need of this service.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Forensic HARPS teams have short-term housing subsidy dollars to assist participants in obtaining and maintaining housing. The amount of subsidy dollars allocated to each team is greater than what the current staffing model allows them to spend. With this additional staff person, the Forensic HARPS teams will be able to fully utilize the subsidy dollars allocated to them. Funding Forensic HARPS teams is cost effective because it diverts individuals with serious behavioral health conditions into receiving the services, they need instead of being arrested or hospitalized. Supportive housing reduces inpatient hospitalization, incarceration and engagement in outpatient treatment increases when individuals are successfully housed (RDA, FCS preliminary outcomes 2020).

Helping individuals obtain and maintain housing of their choice helps them be more successful in treatment. Forensic HARPS teams are trained in leveraging all community resources once an individual exits jail or an institutional setting, but the 'bridge subsidy' is still needed in order to assist individuals exit jail as quickly as possible.

A disproportionate number of individuals of color are represented in our criminal court system. Many of these individuals experience significant barriers in accessing safe and affordable housing. WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. People with trauma, a history of homelessness, and co-occurring disorders have an increased likelihood of being involved in the criminal court system. Helping individuals find and maintain housing of their choice, and obtain wanted services, especially during an increased time of hardship such as COVID-19 is our states responsibility.

Project #: BGCE-RSS36

Project Title: Funding for SSI/SSDI, Outreach, Access, and Recovery (SOAR) Leads

Proposed Budget: \$500,000

Scope:

SSI/SSDI Outreach Access and Recovery (SOAR) is a proven effective model to increase access to governmental benefits. This project would create a SOAR Lead Position in multiple regions/counties (scalable). SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads hold local steering committee meetings, lead SSI/SSDI, Outreach, Access and Recovery (SOAR) online course training cohorts and conduct half-day SSI/SSDI, Outreach, Access and Recovery (SOAR) online course review sessions. SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads will also be mentoring individuals who complete the SSI/SSDI, Outreach, Access and Recovery (SOAR) online course and reporting on outcomes.

This will provide increased access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a serious mental illness. Access to these benefits will help individuals stabilize their housing and health.

Addressing State Needs and Gaps, Including Gaps in Equity:

Many unhoused individuals qualify for disability benefits but have a difficult time getting through the application process. With an SSI/SSDI, Outreach, Access Recovery (SOAR) Representative assisting with the application process, individuals are approved more often and more quickly. Most landlords require some kind of monthly income, this will help provide that and allow more individuals to obtain housing.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS41

Project Title: Enhance Mobile Crisis Teams with CPCs

Proposed Budget: \$1,909,000

Scope:

HCA will build upon the Transformation Transfer Initiative (TTI) crisis services continuing education curriculum for Certified Peer Counselors by piloting enhancements to mobile crisis teams by adding Certified Peer Counselors to existing teams. Funds will be issued to BH-ASOs to expand Mobile Crisis Response services serving those diagnosed with SMI/SED.

This project will provide enhance mobile crisis services by continuing support for certified peer counselors in Washington State. The intended outcome is to increase the engagement and outreach of MCR teams to include certified peer counselors to even more effectively support the peers they serve in crisis settings.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. Expanding mobile crisis services to include Certified Peer Counselors will better support people as Washington expands peer services in crisis settings.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote DEI and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Tribal Projects Detail

Project #: MHAR-TRB1

Project Title: TARGET (database) Replacement

Proposed Budget: \$200,000

Scope:

Based on a pilot to work with a Tribe that currently has EPIC to develop a mechanism to automatically upload SAMHSA-required data to HCA's behavioral health data store, with minimal double entry of data, this project will support the expansion and maintenance of this pilot to other Tribes across the state. This project will offer funding to maintain the behavioral health data system that will replace the previously used TARGET system.

This project will ensure that there is maintenance for the data system that will support the collection of SAMHSA-required data. As the pilot will help HCA to identify if we can use an existing EHR to build the necessary system to meet the needs of the Tribes and the state in SUD and mental health data collection for our reporting to our federal partners/funders and the state legislature, this project will maintain these efforts and address any system improvements needed along with the evolving landscape for behavioral health data collection and reporting.

Addressing State Needs and Gaps, Including Gaps in Equity:

Tribes requested a solution for the TARGET replacement in 2016. Providing funding resources to maintain and improve data collection for Tribes will address a long-time gap for Tribal communities in SUD and mental health data collection in the new integrated health care environment.

This project will systemically improve data reporting and surveillance of AI/AN communities to better address any health disparities. Data is very important in identifying needs and strengths in BIPOC communities.

Project #: MHAR-TRB3

Project Title: Funding to Tribes and Urban Indian Health Organizations

Proposed Budget: \$1,460,114

Scope:

The Health Care Authority will provide contracts to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver needed behavioral health, mental health services for individuals with SMI/SED and substance use disorder prevention, treatment, OUD intervention and recovery supports services within their Tribal communities. Tribes will submit a plan to implement recommended services as outlined in the NOA and allowed within the SABG/MHBG regulations. Additional funds for Tribes will be divided evenly between the Tribes and Urban Indian Health Programs (UIHP) (Native Project & SIHB). These funds will begin on March 2023 - Sept 2025 and may be an extension of the Tribe's and UIHP's COVID Enhancement projects to ensure a full recovery from the impacts of the COVID pandemic.

This project is important because AI/AN and Tribal communities have been greatly affected by the COVID pandemic and the various Tribal and State Stay at Home Orders. Tribes are identifying ways to maintain some of their BH program in a virtual and semi/virtual environment. Due to the pandemic, Tribes are stating that the individuals in their communities are struggling with social isolation and a lack of treatment services due to the pandemic. There has also been limited cultural activities available for Tribal communities due to the pandemic. The historic annual Canoe Journey was canceled two years in a row with very limited ability to implement cultural programs across all Tribal communities. These funds will support the Tribe's and UIHP's ability to address any gaps and needs in their behavioral health services and increase support individuals that may have lingering behavioral health impacts due to the COVID 19 pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

Department of Health (DOH) reported that overdose rates have gone up over 154% during the first 6 months of the pandemic and is the highest of other communities by race/ethnicity. The statewide increase overall is 30%. The Health Care Authority needs to continue to provide resources to Tribal communities to address those diagnosed with SMI or SED for American Indian/Alaskan Native (AI/AN) in WA. Providing direct funding to Tribes and Urban Indian Health Programs (UIHPs) also honors our government-to-government relationships by partnering with Tribes to serve American Indian/Alaskan Native WA State residents.

This project directly supports Diversity, Equity and Inclusion (DEI) by providing needed services to the American Indian/Alaskan Native (AI/AN) population in providing culturally appropriate services. This also honors our unique Government-to-Government (G2G) relationships with Tribal governments and our partnership with Urban Indian Health Programs (UIHPs).

Crisis Services:

Tribes and Urban Indian Health Programs (UIHPs) may provide crisis services with these funds. The Health Care Authority will pass down National Guidelines to Tribes to provide guidance on best practices for crisis services.

Crisis Set-Aside Projects Detail

Project #: MHAR-ASO2

Project Title: Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding for Crisis Services

Proposed Budget: \$3,320,228

Scope:

Funding directed to the Behavioral Health Administrative Service Organizations (BH-ASO's) will support their respective crisis provider networks enhancing the provision of comprehensive community mental

health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. Funding will be used to enhance existing Crisis Services provided 24 hours a day, seven days a week including crisis call line, evaluation and treatment services for Individual's ineligible for Medicaid, including involuntary inpatient services, voluntary inpatient services, crisis stabilization services, Employment and Training (E&T) services, and services for the priority populations defined per Contract. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retainment issues that have increased throughout the behavioral health delivery system during the pandemic. All funded crisis workers will be required to be trained in trauma informed care, de-escalation techniques and the fundamentals of harm reduction.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that policies and procedures have had different negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation. Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based mental health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health and substance use crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments; and strategies to reduce the fragmentation of mental health care.

Technology Infrastructure Projects Detail

Project #: MHAR-TEC1

Project Title: Clinical Data Repository

Proposed Budget: \$325,000

Scope:

This funding request is to support technological enhancements to the CDR that will allow retention of historical clinical data, including MH/SUD data, as well as implementation of an analytic enclave environment. This solution will allow authorized users, including researchers, evaluators, state staff, clinicians and others to access protected health information in a secure environment in order for them to conduct their research and analyses, without the need for these data to leave the CDR secure environment. This will support programmatic enhancements, overall program governance, and analytics in order to achieve meaningful results and support other key efforts such as Value Based Purchasing, Health Care Transformation and Health Care Cost/Quality Transparency.

The current Medicaid CDR was established several years ago. There is now a need to enhance the current CDR and define a strategic vision focused on clinical quality and outcome analytics, total cost of care analytics and care coordination functions especially focused on MH/SUD clients. Washington's CDR presents a unique opportunity to develop a true clinical data warehouse that is leveraged in conjunction with other State data assets such as the All-Payer Claims Database (APCD), the Health Information Exchange (HIE), Public Health disease registries and others, to generate true total cost of care and care quality/outcome analytics to inform research, policy and health system transformation.

Addressing State Needs and Gaps, Including Gaps in Equity:

Care coordination for MH/SUD clients is greatly impeded currently by a lack of seamless data exchange between providers. The CDR is a critical data asset which has the capabilities to help bridge this gap. This investment will significantly enhance the technological ability of this tool to enable appropriate and secure data sharing amongst those who need it in order to better serve the MH/SUD clients in Washington.

Medicaid clients who need MH/SUD services are amongst the most vulnerable populations in our care. As stated above, care coordination for MH/SUD clients is greatly impeded currently by a lack of seamless data exchange between providers. The CDR is a critical data asset which has the capabilities to help bridge this gap and help enhance equitable access to information about clients to their providers. This investment will significantly enhance the technological ability of this tool to enable appropriate and secure data sharing amongst those who need it in order to better serve the MH/SUD clients in Washington.

Health IT Infrastructure

The Clinical Data Repository as implemented in the state of Washington is compliant with health information technology standards and implementation specifications as identified in 45 CFR 170, Subpart B.

Project #: MHAR-TEC2

Project Title: Consent Management Solution

Proposed Budget: \$1,300,000

Scope:

The electronic consent management solution, which has been approved by Washington State HHS agencies, will be a key foundational investment in the state's health information exchange infrastructure and will enable meaningful, seamless exchange of protected and sensitive BH and PH information amongst those who are authorized to receive it in order to deliver services to Washingtonians.

Every initiative to support Behavioral Health Integration requires Behavioral Health (BH) and Physical Health (PH) data to be seamlessly shared amongst clinicians, and across the care continuum. Care coordination, case management, population health and even public health, as evidenced during this past year, are highly dependent on this seamless exchange of information. In addition to direct care clinicians, others in the care system such as care coordinators, case managers, managed care organizations, public health entities and others also need access to such data in order to be able to fulfill their respective missions. Lack of a standardized, centralized consent management solution has presented a significant barrier to realizing true BH-PH integration.

Addressing State Needs and Gaps, Including Gaps in Equity:

Care coordination for MH/SUD clients is greatly impeded currently by a lack of seamless data exchange between providers. A centralized consent management solution is a critical investment which will provide the capabilities to help bridge this gap. This investment will significantly enhance the technological ability that enables appropriate and secure data sharing amongst those who need it in order to better serve the MH/SUD clients in Washington.

Medicaid clients who need MH/SUD services are amongst the most vulnerable populations in our care. As stated above, care coordination for MH/SUD clients is greatly impeded currently by a lack of seamless data exchange between providers. A centralized consent management solution is a critical investment which will provide the capabilities to help bridge this gap and help enhance equitable access to information about clients to their providers. This investment will significantly enhance the technological ability to enable appropriate and secure data sharing amongst those who need it in order to better serve the MH/SUD clients in Washington.

Health IT Infrastructure

The consent management solution will meet health information technology standards and implementation specifications as identified in 45 CFR 170, Subpart B. Specifically, the consent management solution will be interoperable with ONC certified Electronic Health Record (EHR) systems and will use HL7 FHIR standards for secure data exchange between systems.

Project #: SAAR-TEC3

Project Title: Statewide Bed Registry

Proposed Budget: \$1,414,478

Scope:

This project will develop and implement a statewide bed registry to track capacity and real-time bed availability for psychiatric hospital beds, freestanding evaluation and treatment center beds, Secure Withdrawal Management and Stabilization Beds, crisis triage/stabilization beds, and substance use disorder residential treatment beds. The registry is intended to include both adult and youth/child beds.

Contracted resources will be utilized to implement this new solution, with management of maintenance and operations to be supported by existing staff resources.

The lack of a statewide bed registry has been a long-standing problem within the state. The need has been discussed in multiple work groups. This would include the legislative BHRST group and the ITA Work Group required by SB 5720. Both these workgroups have included stakeholder and consumer testimony on how difficult it is for a crisis worker, an individual or family member to find an available treatment bed. Currently, without a bed registry, multiple facilities have to be called to see if they provide the appropriate treatment services and to see if they have any vacant beds. Sometimes this process involves calling up to 20 facilities. Implementation of a registry will make it significantly easier to locate beds and access care. If this is not approved, crisis workers, individuals and families will continue to face obstacles in accessing critical care.

Addressing State Needs and Gaps, Including Gaps in Equity:

Ready access to mental health and substance use disorder treatment beds will benefit all populations. We know that due to social determinants of health and historical trauma, there is a disproportionate need for care for BIPOC individuals. That care should be readily available.

Health IT Infrastructure

The Statewide Bed Registry in the state of Washington will be compliant with health information technology standards and implementation specifications as identified in 45 CFR 170, Subpart B.

Washington

American Rescue Plan Act Funding Work Plan for FY22-25

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

Center for Mental Health Services
Division of State and Community Systems Development

Mental Health Block Grant APRA Funding Plan

WA State Summary

The COVID-19 pandemic has had a significant impact on people with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) in Washington State. During the first half of 2019, 8.2% of adults over 18 years of age had symptoms of anxiety disorder and 6.6% had symptoms of depressive disorder. By comparison, in the most recent Household Pulse Survey from the Centers for Disease Control examining trends from February 17, 2021, to March 1, 2021, this prevalence quadrupled to 33.4% for anxiety and 27.7% for depression (in Washington state, rates were slightly higher with 34.2% for anxiety, 14th highest of the 50 states, and 27.8% for depression, 23rd highest of the 50 states). The age group with the highest prevalence rates nationally is 18–29-year-olds (47.2% reporting anxiety, and 42.2% reporting depression). The devastating impacts of the COVID-19 pandemic have clearly impacted young adults' mental health and substance use (a population already at high risk).

As the state and nation emerge from early Phases of the pandemic, the resulting impacts of the last year are a salient concern. People face potentially new obstacles such as continued mental health issues, overcoming the potential disruptions in school, work, and finances, and re-engaging in social life with continued recommendations from the CDC and local health departments (e.g., mask mandates). This is a critical time to address potential harms and to encourage engagement in both adaptive coping behaviors and unique strategies of social engagement within current public health guidelines to reduce high-risk substance use and worsening mental health symptoms, in both adults and youth.

HCA's Division of Behavioral Health and Recovery has reviewed the *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* and allocated a percentage of the total potential American Rescue Plan Act (ARPA) funding to address principles focused on recovery needs, support for the behavioral health workforce, particularly of Peers and Recovery Support Peers, and trauma-informed treatment services. Our intention is to use the ARPA funding to sustain projects originally funded through the Covid Supplemental award through September 2025, which will result in some of our contracts not being executed until March 2023. In addition to extending support for those projects, we are also adding in new funding for suicide prevention and technology infrastructure. The budget summary, on the following pages, provides the detailed amounts allocated across the continuum of behavioral health services through a wide variety of projects, treatment funds provided through our Behavioral Health Administrative Service Organizations (BH-ASOs) and Tribes. The Washington Health Care Authority respectfully submits the proposals you will find in the pages to follow.

As part of our effort to seek stakeholder input, the Behavioral Health Advisory Council co-hosted a meeting with the Health Care Authority to invite input from various partners and representatives from across the state's behavioral health system (from Peers to school districts, as well as counties, managed care organizations and others) on priorities for the Covid-19 Supplemental funding. Input on the proposals was received at the end of the event, which helped to inform the direction, as well as solidify the allocations to each section. We are utilizing the input received from this to guide us in our investments using the ARPA funding as well. The Health Care Authority may also require some flexibility to move allocations from one proposal, to another, within those in this application, in the event a

particular proposal is particularly successful and requires funding allocation from another proposal which may not require the entire allocation presented in this application. Additionally, the Washington Legislature will require the review and approval of our workplan in the 2023 Legislative session, which may create the need to shift funding based on their decisions at that time.

Within the budget summary below, you will find the proposed project titles, a brief description and number for each project under the sections of Prevention, First Episode Psychosis, Treatment, Recovery Support Services, Tribal, Crisis Services and Technology Infrastructure. In the pages that follow, a longer project narrative will include the project title, budgeted amount, a description, or scope of work summary, as well as a narrative of how the project addresses state needs and gaps, especially gaps in equity.

WA is grateful to SAMHSA for the opportunity to apply for the ARPA funds, as this has been an unprecedented year of extreme stressors to the most vulnerable among us, and the funding will undoubtedly support those persons at greatest risk, as well as those who seek support in treatment and ongoing recovery.

Project List and Budget Table

Prevention			
Project #	Project Title	Project Description	Proposed Budget
MHAR-Px1	Suicide Prevention	Develop and expand programming for new and continuing community-based organizations with a specific focus on suicide prevention in high-need communities.	\$1,660,114
Total Prevention Set-Aside			\$1,660,114
FEP Set-Aside			
Project #	Project Title	Project Description	Proposed Budget
MHAR-CYF1	Rural and AI/AN Evidence Based Coordinated Specialty Care for FEP	Develop and adapt evidence based coordinated specialty care programs for FEP to meet the needs of rural, frontier and AI/AN communities.	\$3,984,273
Total FEP Set-Aside			\$3,984,273
Treatment			
Children, Youth and Family Treatment Funding			
Project #	Project Title	Project Description	Proposed Budget

MHAR-CYF2	Developing Wraparound and Intensive Services (WiSe) Workforce Support	Developing Wraparound and Intensive Service (WiSe) workforce to support youth with Intellectual Disabilities/Developmental Disabilities (including Autism Spectrum Disorder (ASD)).	\$600,000
MHAR-CYF5	Trauma Focused Cognitive Behavioral Therapy Training	Trauma Focused Cognitive Behavioral Therapy (CBT) Training for clinicians serving children and youth returning to school as part of the triage process post screening.	\$376,671
Adult Treatment Funding			
MHAR-MHA1	Cognitive Behavioral Therapy for Psychosis	Expansion of current contract to deliver Cognitive Behavioral Therapy for Psychosis to a cohort of clinicians who are serving people on 90/180 involuntary civil commitment orders.	\$130,000
MHAR-MHA3	Mental Health Specialist Training	Provide training via a 100-hour course for Mental Health (MH) professionals to secure credentials to become an Older Adult Mental Health Specialist, Intellectual Disabilities /Developmental Disabilities (ID/DD) Mental Health Specialist, and Ethnic Minority Mental Health Specialist.	\$396,671
BH-ASO Treatment Funding			
MHAR-ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding	The community mental health services provided include but are not limited to outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, residents of the service areas who have been discharged from inpatient treatment at a mental health facility, day treatment or other partial hospitalization services, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, or ready for discharge from inpatient psychiatric care, and individuals residing in rural areas.	\$10,066,183
Total Treatment			\$11,569,525
Recovery Support Services			

Project #	Project Title	Project Description	Proposed Budget
MHAR-RSS1	Participant Support Funds-Housing and Recovery through Peer Services (HARPS) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$50,000
MHAR-RSS2	Participant Support Funds-Projects for Assistance in Transition from Homelessness (PATH) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$140,000
MHAR-RSS3	Participant support Funds - Peer Bridger	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$100,000
MHAR-RSS12	Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams	Targeted peer outreach on Project for Assistance in Transition from Homelessness (PATH) teams focusing on a by-name list of individuals who have had multiple contacts with crisis system.	\$1,759,433
MHAR-RSS14	Operating costs for a housing inventory/estimator/calculator	Provide timely information for individuals with behavioral health conditions to access housing services and resources.	\$10,000
MHAR-RSS16	Supportive Housing Institute	Corporation for Supportive Housing (CSH) curriculum to increase the number of affordable housing development for individuals with mental health and substance use disorders.	\$150,000
MHAR-RSS19	Cover Foundational Community Support Services in Institution for Mental Disease (IMD) when Medicaid is Suspended	Utilize block grant funds that would cover Foundational Community Support services for people transitioning out of Institution for Mental Disease (IMD) settings if Medicaid does not get retroactively reconnected.	\$500,000

MHAR-RSS24	Peer Pathfinders Transition from Incarceration Pilot	Enhance jail transition programs with SUD peers services to individuals who upon release will be homeless. SUD Peer Services begin prior to release to establish relationship and upon release to support the transition to needed services.	\$790,000
MHAR-RSS25	Add Co-Occurring Peer to Forensic-Housing Housing and Recovery through Peer (F-HARPS) Services	Add 1 peer to each of the four Forensic-Housing Housing and Recovery through Peer Services (F-HARPS) in Phase I regions.	\$400,000
MHAR-RSS36	Funding for SSI/SSDI Outreach, Access, and Recovery (SOAR) Leads	Helping individuals with the creation of a Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) outreach access and recovery community coordinators.	\$500,000
MHAR-RSS41	Enhance Mobile Crisis Teams with CPCs	Pilot enhancements to mobile crisis teams by adding CPCs to existing teams.	\$1,909,000
Total Recovery Support Services			\$6,308,433
Tribal			
Project #	Project Title	Project Description	Proposed Budget
MHAR-TRB1	TARGET (database) Replacement	TARGET replacement program for SUD and mental health data.	\$200,000
MHAR-TRB3	Funding to Tribes and Urban Indian Health Organizations	Provide funding to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver treatment for individuals diagnosed with SMI/SED, prevention, treatment, and recovery support services within their Tribal communities.	\$1,460,114
Total Tribal			\$1,660,114
Crisis Set-Aside			
Project #	Project Title	Project Description	Proposed Budget
MHAR-ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding - Crisis Services	Services include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responders (DCR) services.	\$3,320,228

Total Crisis Set-Aside			\$3,320,228
Technology Infrastructure			
Project #	Project Title	Project Description	Proposed Budget
MHAR-TEC1	Clinical Data Repository	Support technological enhancements to the CDR that will allow retention of historical clinical data, including MH/SUD data, as well as implementation of an analytic enclave environment.	\$325,000
MHAR-TEC2	Consent Management Solution	Enable meaningful, seamless exchange of protected and sensitive BH and PH information amongst those who are authorized to receive it in order to deliver services to Washingtonians.	\$1,300,000
MHAR-TEC3	Statewide Bed Registry	Develop and implement a statewide bed registry to track capacity and real-time bed availability for psychiatric hospital beds, freestanding evaluation and treatment center beds, Secure Withdrawal Management and Stabilization Beds, crisis triage/stabilization beds, and substance use disorder residential treatment beds.	\$1,414,478
Total Technology Infrastructure			\$3,039,478
TOTAL MHBG Covid Supplement Budget			
Suicide Prevention			\$1,660,114
FEP Set-Aside			\$3,984,273
Treatment			\$11,569,525
Recovery Supports Services			\$6,308,433
Tribal			\$1,660,114
Crisis Set-Aside			\$3,320,228
Technology Infrastructure			\$3,039,478
Administrative			\$1,660,114
Total Budget			\$33,202,279

Prevention Project Detail

Project #: MHAR-Px1

Project Title: Suicide Prevention

Proposed Budget: \$1,660,114

Scope:

Washington State is facing an increased demand for suicide prevention services both before and in the face of the COVID-19 pandemic. To address the social and mental health needs of communities, the Washington Health Care Authority is requesting \$1,660,114 for 2022 through 2025 to implement and expand projects/programs in communities where there is a demonstrated need for suicide prevention. The requested funds represent costs associated with the performance and administration of suicide prevention projects to community-based organizations in the state. HCA suicide prevention projects are direct service evidence-based, promising, and evidence-informed strategies with a focus in high-need communities. These services ensure that WA State keeps pace with best practices and has current training in providing services. Suicide prevention services are crucial for all communities in Washington, but current funding levels limit the reach of state sponsored programming. Of the twenty-three community-based applicants requesting suicide prevention funding, only twelve organizations were awarded based on current state funding levels despite the record number of quality submissions for the RFA. This demonstrates a need for suicide prevention in the state that is not currently being met due to funding, not capacity, limitations.

The current proposal/project asks for funds to develop and expand programming for new and continuing community-based organizations with a specific focus on suicide prevention in high-need communities. The expanded programming will include:

- Evidence-based and promising programs identified on one or more evidence-based lists showing effectiveness for mental health and/or suicide prevention outcomes.
- Mental health First Aid and/or Youth Mental Health First Aid provided to individuals working in populations with individuals who may be experiencing suicidal ideation to recognize signs and connect individuals to resources.
- Youth and parent programs focused on reducing stigma and encouraging individuals to seek help.
- Information dissemination campaigns that target individuals at higher risk for death by suicide.
- Evaluation of programming to assess desired outcomes being met.
- Continued training and professional development opportunities for partners and coordinators of suicide prevention programming to ensure information sharing and implementation of best practices.

The global COVID-19 pandemic presents new and continued challenges in mental health promotion and suicide prevention in the State of Washington. Before the pandemic, the number of suicides in Washington State increased by 13 percent from 2016 to 2019, with a raw increase of 1123 deaths in 2016 to 1263 deaths in 2019 (WA DOH, 2020). According to preliminary data from the Washington Department of Health in December 2020, the ongoing pandemic has the potential to create a disaster

cascade, causing the risk of suicide, depression, hopelessness, and substance use to increase due to isolation, stress, and fear from the economic, physical, social consequences of the crisis. This is especially felt among specific high-risk groups who are unable to access healthcare or other necessary resources, like young adults, LGBTQ+, certain occupational groups, and persons who are undocumented. Youth data collected in Washington State during the pandemic reflect this. According to the COVID-19 Student Survey (CSS), 45 percent of middle school students and 58 percent of high school students that completed the survey reported feeling sad or depressed most days in the past 12 months, as compared to 32 percent of middle school students and 41 percent of high school students self-reported in the 2018 Health Youth Survey. (Note, while CSS and HYS are not directly comparable due to administration methods, it does provide context for comparison.) Though students reported higher rates of depression and sadness during the pandemic, around two thirds of respondents reported feeling hopeful about the future, demonstrating a social momentum that the State can capitalize on.

The anticipated outcomes of being able to fund suicide prevention efforts in high-need communities throughout the state of WA include decreased risk of suicide ideation and ultimately lower rates of death by suicide. By allowing communities to identify local solutions to local problems under a framework that has demonstrated outcomes, impacts are optimized, inclusion and cultural competency around local populations are respected, sustainability is integrated in the process, and lives are saved. Communities funded at current levels have seen a positive change with the implementation of evidence-based suicide prevention programming. Snohomish county, in western Washington, has experienced a statistically significant reduction in suicide attempts across all grades as a direct result of our previous MHPP funded suicide prevention efforts; the self-reported suicide attempt rate dropped from 17.1% of 10th graders in 2016, to just 6.7% in 2018, and when looking at the same graduating class of student from 2018, the self-reported suicide attempt rate dropped from 17.1% of 10th graders in 2016 to just 10.0% for that same graduating class as 12th graders in 2018 (HYS, 2002-2018). Without MHPP CBO funding, and other Districts around Washington State, are left without adequate Mental Health Promotion and Suicide Prevention funding.

C25	Monroe School District 10th Grade NO Adult to Turn Rates (HYS)							
2002	2004	2006	2008	2010	2012	2014	2016	2018
n/a	n/a	18.1%	19.9%	16.6%	15.3%	15.4%	13.7%	8.2%

H56	Monroe School District 10th Grade Attempted Suicide Rates (HYS)							
2002	2004	2006	2008	2010	2012	2014	2016	2018
9.8%	8.6%	5.6%	12.3%	9.8%	8.3%	8.0%	17.1%	6.7%

With additional funding we will be able to support additional communities like Snohomish County and short-term outcomes that include a decrease in youth reporting symptoms of depression, anxiety, and suicidal ideation as reported on our WA State Healthy Youth Survey. Longer term impacts include decreased suicide ideation, attempts, and deaths across the WA populace. Without these pointed efforts that are developed, implemented, and owned by the community, there is an increased likelihood that outside efforts will not align with local readiness, cultural nuances, and, in the end, lack sustainability. This ultimately leads to a lower quality of life for Washingtonians and preventable death.

Addressing State Needs and Gaps, Including Gaps in Equity:

The success in Snohomish County illustrates the impact of community driven solutions on the rate of suicide among high-risk groups. But despite these accomplishments, the rate of suicide in Washington State is still higher than the national average. The suicide rate in Washington has increased from 13.8 percent in 2010 to 16.2 percent in 2019, compared to the national suicide rate which increased from 12.4 to 14.8 over the same time. For Washington State, that equates to 11,160 lives lost due to suicide from 2010 to 2019, and countless other family and community members lives affected after suicide (WA DOH, 2020). According to the state Suicide Prevention Plan, an average of 65 people in Washington each week are hospitalized due to intentional self-inflicted injuries. The Centers for Disease Control estimates that suicide and suicide attempts cost society about \$70 billion a year nationally in combined medical and work loss costs.

As the state and nation transition to a different phase of the pandemic, high risk individuals like young adults, face potentially new obstacles such as continued mental health issues, overcoming the potential disruptions in school, work, and finances, and re-engaging in social life with continued recommendations from the CDC and local health departments (e.g., mask mandates). There is a critical need for suicide prevention outreach and programs. This is a critical time to address potential harms and to encourage engagement in both adaptive coping behaviors and unique strategies of social engagement within current public health guidelines to reduce high-risk substance use and worsening mental health symptoms.

We know that suicide impacts different populations in WA disproportionately. LGBTQ youth in particular. While some of this is attributed to factors such as access to lethal means and distance from medical facilities, some is attributable to social determinants of health and other factors that are nuanced within community. By utilizing a framework, the focuses on community identified and implemented solutions, and ensuring that this framework considers local conditions and factors, optimized outcomes become much more likely. This is particularly true when the application of the framework is inclusive of data and engagement of the target population in the process.

Current funding is insufficient to meet demand for suicide prevention and crisis intervention. This is a significant public health issue as WA State's suicide rate continues to increase. WA needs funding for adequate services in suicide prevention, intervention, treatment, and post-vention (resource provided in the aftermath of suicide) so we can support individuals, families, and communities affected by suicide deaths.

The CDC Household Pulse survey from late February 2021, symptoms of anxiety disorder were reported by a greater percentage of participants who identified as non-Hispanic, other races and multiple races (42.8%), Hispanic or Latino (36.9%), or non-Hispanic, black, single race (35.5%) than those who identified as non-Hispanic white, single race (32.1%). According to the Washington Department of Health, 2020 compared to 2019 saw an increase in suicides among person who identify as Hispanic (WA DOH, 2020).

With evidence suggesting disproportionate impact of the COVID-19 pandemic on communities of color, and with other evidence suggesting less help-seeking and/or utilization of counseling or services requiring interaction with others (both within the 18–29-year-old age group and within select racial/ethnic groups), programming that supports suicide prevention for these high-risk groups is desperately needed.

First Episode Psychosis Project Detail

Project #: MHAR-CYF1

Project Title: Rural and AI/AN Evidence Based Coordinated Specialty Care for FEP

Proposed Budget: \$3,984,273

Scope:

This additional project amount would be to develop and adapt evidence based coordinated specialty care (CSC) programs for first episode psychosis (FEP) to meet the needs of rural, frontier, AI/AN communities, and other special populations; with the necessary support to operationalize the projects in a timely manner. The project would be to help to develop a rural and /or Tribal New Journeys/CSC model, to evaluate it, and broadly disseminate the results to inform future program development. This model can expand to other specific populations as the work advances. Other states are also interested in figuring out how to develop CSC services in rural areas and Tribal communities and other specific populations. There could be great value in collaborating with partners in other states on this (they would fund their own program development) and could help to define rural and AI/AN CSC in other parts of the U.S.

This work is critical to accomplish the legislative mandate in SSSB 5903 requiring statewide expansion of treatment for FEP. Specialized knowledge and adaptation are essential to meet the unique needs of sparsely populated regions and minority communities in order to achieve the goal of decreasing the duration of untreated psychosis. Considering the magnitude of the impact of schizophrenia, interventions designed to treat the disorder effectively at the earliest possible point (e.g., during the first episode of psychosis) have the potential to improve its long-term trajectory, improve outcomes, improve lives, save lives and save health care dollars and to reduce the health care burden of the illness. The longer a person goes untreated, the more severe and chronic their symptoms become, often resulting in decreased functioning and other negative outcomes over their lifetime.

Addressing State Needs and Gaps, Including Gaps in Equity:

Initial examination of 2018 Medicaid data indicate that extra support is needed to ensure that intervention with first episode is equally available in rural geographical areas and in AI/AN communities. The data suggest there are existing geographical disparities and AI/AN disproportionality. The Washington State Legislature, Children's & Youth Behavioral Health work group (CYBWHG) and SAMSHA have all prioritized early identification and intervention for psychosis. This is so screening and early identification of psychosis among adolescents and young adults will become a universal health care practice, and evidence-based recovery interventions will be available to those who need them.

Treatment Projects Detail

Children, Youth and Family

Project #: MHAR-CYF2

Project Title: Developing Wraparound and Intensive Services (WiSe) Workforce Support

Proposed Budget: \$600,000

Scope:

Expansion of Workforce & Enhancing Local Care Networks to support Youth with Intellectual or Developmental Disabilities including Autism Spectrum Disorder.

Based on the initial model, identify additional WiSe behavioral health agencies each year to plan and implement the project informed by local needs with logistical oversight provided the WiSe Workforce Collaborative/En Route. Develop glide path for more expansive reach of focused special population services. A training component will be provided by Seattle Children's Autism Center and offered to additional BH agencies. The proposed RUBI training model will include:

- (1) An initial 16-hour workshop attended by all WiSe team providers;
- (2) 20 weeks of ongoing consultation with the WiSe team mental health therapist
- (3) Fidelity review of WiSe therapist implementation of RUBI sessions

Agencies selected will have been involved in the HCA and DDA convened WiSe and ID/DD and ASD workgroup or Project Echo sessions. This allows the project to build more directly on the knowledge and efforts already in process.

The three lead agencies will dedicate a portion of a staff time to participate in developing the specialty team model, attend training, learning collaboratives and consultation. Lead sites will also convene community partners to plan for enhancing their local care network to support youth with ID/DD and ASD.

During COVID the increased need of trained staff to provide stabilization support for youth in WiSe with ID/DD including ASD has become apparent. The concern identifying the need for additional training has been expressed by caregivers, behavioral health agency staff and allied system partners. Our behavioral health workforce is often times generalists by education and don't have the training to best support youth with ASD and their families. This funding would provide the training support and consultation to

five behavioral health agencies as well as enhance community coordination in three regions for youth enrolled in WISe with ID/DD including ASD.

Addressing State Needs and Gaps, Including Gaps in Equity:

Provides workforce training and development to address the need in providing co-occurring services for youth with ID/DD including ASD. Also provides funding for community coordination and input from youth, families and system partners.

The community coordination and development of this project would include outreach to BIPOC communities to participate and provide insight to specific community needs.

Project #: MHAR-CYF5

Project Title: Trauma Focused Cognitive Behavioral Therapy Training **Proposed Budget:** \$376,671

Scope:

Continue to provide training in TF-CBT to clinicians serving children and youth returning to school as part of the triage process post screening as a part of the recommended DOH fast response plan to help meet the needs of children and youth returning to school following the Governor's proclamation that in person options are required as of April 1, 2021. This will allow clinicians to continue to serve youth who indicate trauma exposure in the screening process (SED) following the pandemic to support increased access to necessary mental health supports. This will advance the Sonoma model and further enhance the clinical interventions available to children and youth across WA.

The Governor issued a proclamation that in person options be available across WA as of April 1, 2021. The potentially unmet needs of children and youth throughout the pandemic regarding mental health impact are expected to surface as children youth and families begin the transition to in person education. This proposal meets an identified need, and the timeline will ensure that trauma informed clinical interventions will be available to children and youth as transition back to school and acclimate to new norms.

Addressing State Needs and Gaps, Including Gaps in Equity:

The workforce serving children youth and families across Washington are dedicated to the age group and the developmentally appropriate interventions needed. This training further supports them in an evidence-based response to the expected wave of trauma exposure from impacts of the pandemic, to support and serve with resilience and strength based approaches and supports in pushing back compassion fatigue in ensuring they have the tools they need to feel effective in their work, resulting in resilient communities.

Efforts will be made to ensure training is offered to diverse clinician groups including BIPOC and LGBTQ+ clinician groups.

Adult Treatment

Project #: MHAR-MHA1

Project Title: Cognitive Behavioral Therapy for Psychosis

Proposed Budget: \$130,000

Scope:

This project will continue to enhance the workforce serving individuals with psychosis by delivering Cognitive Behavioral Therapy for Psychosis training and technical assistance to a cohort of outpatient and inpatient clinicians from selected contracted community-based sites who are serving people receiving 90/180-day involuntary civil commitment orders. This EBP helps people living with psychosis achieve a level of self-management that has shown great success, supporting individuals and their families in the community.

Training outpatient behavioral health agency staff and their locally corresponding contracted long term civil commitment sites in an appropriate EBP should assist this population in better managing their symptoms and reduce their need for further involuntary or inpatient treatment.

Addressing State Needs and Gaps, Including Gaps in Equity:

Training on CBT for Psychosis will help empower individuals with psychosis to better manage symptoms that interfere with their ability to live their lives in the community. The BH workforce needs enhanced tools to treat psychosis beyond simply medication alone and this EBP is targeted to the needs of a population that traditionally does not receive therapy as many clinicians do not know about CBT for Psychosis and its success rate.

People living with psychosis experience much social isolation due to their symptoms. By providing them with greater skills to manage psychosis, this inequity will be better addressed. This enhancement will serve all populations living with psychosis, including members of BIPOC communities but is not a targeted outreach to them specifically.

Project #: MHAR-MHA3

Project Title: Mental Health Specialist Training

Proposed Budget: \$396,671

Scope:

Provide training via a 100-hour course for Mental Health Professionals to secure credential to become an Older Adult MH Specialist, Intellectual/Developmental Disabilities Mental Health Specialist, and Ethnic Minority Mental Health Specialist as defined in Washington's Rehab State Plan for Mental Health Outpatient treatment. Training curricula will focus on recognizing unique needs of these populations, clinical best practices, understanding of the community resources and partners when working with these populations, the role of the Mental Health Specialist, and how to provide clinical consultation, cultural humility, and other relevant information specific to each demographic.

The Division of Behavioral Health and Recovery has not sponsored MH Specialist academies for almost 10 years and as such, there are significant workforce shortages in specialists trained and credentialed to work with these populations. Each has their own unique needs or considerations that impact care and the BH workforce needs additional training and support in order to meet these needs.

Addressing State Needs and Gaps, Including Gaps in Equity:

With a fast-growing aging population, the need for MHPs trained and sufficiently skilled to work with older adults is more critical than ever. The current workforce requires specialized skills and knowledge to better support BIPOC populations and people with intellectual or developmental disabilities. This workforce shortage must be addressed.

BIPOC communities, older adults, and people with Intellectual Disabilities/Developmental Disabilities must receive culturally appropriate services from clinicians with relevant education, experience, and skills. This is a matter of equity and parity.

BH-ASO Treatment Funding

Project #: MHAR-ASO2

Project Title: Behavioral Health Administrative Services Organization (BH-ASO) Treatment Funding

Proposed Budget: \$10,066,183

Scope:

Funding directed to the Behavioral Health Administrative Services Organizations (BH-ASO) will support their respective provider networks enhancing the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. This includes a regionally based system of care that includes mental health services to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities. Including increasing capacity of Designated Crisis Responder (DCR) and Tribal Designated Crisis Responder (DCR) services.

The community mental health services are provided to individuals with serious mental illness/serious emotional disturbance including specialized outpatient services for American Indian/Alaskan Native (AI/AN), children, and the elderly. Services provided include but are not limited to outpatient services for individuals who have been **discharged** from inpatient treatment, day treatment, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, and individuals residing in rural areas. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental

health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retainment issues that have increased throughout the behavioral health delivery system during the pandemic.

If funding were not approved the statewide behavioral health service delivery system will continue to face funding gaps, service delivery delays, and individuals diagnosed with Serious Mental Illness (SMI), or Serious Emotional Disturbance (SED) will be less likely to have opportunities to access services and function better in their communities experiencing an improved quality of life. Further, an opportunity to enhance and improve ongoing behavioral health system workforce recruitment and staff retention worsened by the pandemic will be missed.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support, and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that policies and procedures have had negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation.

Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based behavioral health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments.

Recovery Support Services Projects Detail

Project #: MHAR-RSS1

Project Title: Participant Support Funds – Housing and Recovery through Peer Services (HARPS) Teams

Proposed Budget: \$50,000

Scope:

Adding additional support funds to each Housing and Recovery through Peer Support (HARPS contract to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination of other healthcare services and case management.

We expect the housing crisis and behavioral health crisis to intensify as eviction protections are lifted. The HARPS priority population is unable to earn wages while involved with inpatient treatment and is unlikely to have savings to secure housing upon discharge. Additionally, many participate intensive outpatient treatment which limits the amount of time to earn wages to afford housing, as well as other necessities to stay engaged in treatment and recovery activities.

Adding additional support funds to each Housing and Recovery through Peer Services (HARPS) contract to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination of other healthcare services and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Participant Support Funds will help the Housing and Recovery through Peer Support (HARPS) Teams to interweave care coordination, case management, and outreach services. People experiencing homelessness and behavioral health conditions benefit from connections to peer services and resources.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: MHAR-RSS2

Project Title: Participant Support Funds – Projects for Assistance in Transition from Homelessness (PATH) Teams

Proposed Budget: \$140,000

Scope:

Proposed support service funds will be added to the current contracted programs, Projects for Assistance in Transition from Homelessness (PATH). PATH programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency will be required to develop a detailed plan describing method and intended outcome for allocating client support service funding and submit to the Health Care Authority for approval by 09/30/2021. Plan must be based on Mental Health Block Grant (MHBG) guidance for Target Population* and Statement of Work.

Persistent and consistent outreach and providing services at the individual's pace are important steps to engage people with serious mental illness who are homeless. The proposed support service funds will enhance the quality of program delivery and engagement and expand critical client resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

Homeless outreach services intention is to reach individuals who are not currently engaged in services and potentially unable to navigate the system. The ability to have support services that offer basic needs upon engagement increases the likelihood for engagement in treatment and recovery.

PATH teams serve individuals experiencing homelessness and Serious Mental Illness (SMI) to BIPOC communities. BIPOC communities are overrepresented in homelessness. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: BGCE-RSS3

Project Title: Participant Support Funds – Peer Bridger

Proposed Budget: \$100,000

Scope:

The goal of this project is to use participant funds to connect people to community supports and treatment and reduce recidivism to the state hospital admissions. Keeping individuals engaged in peer services creates personal connection, accountability, and someone to assist in navigating complicated systems. Without these added supports the system continues to be a revolving door for many.

MHBG Funds could be used to support case managers, outreach workers, Assertive Community Treatment Services For people experiencing homelessness, medications, coordination with primary care, and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support improves engagement and increases hope by modeling recovery. These complimentary services will enhance the already proven Peer Bridger model.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: MHAR-RSS12

Project Title: Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams

Proposed Budget: \$1,759,433

Scope:

Proposed funds will continue funding for one peer counselor to the current Projects for Assistance in Transition from Homelessness (PATH). PATH programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency hired a peer counselor to expand outreach and engagement services for individuals with a serious mental illness (SMI) and homeless or at risk of homelessness utilizing the Block Grant Covid Supplemental funding, this will continue support for those positions through mid-2025. Projects will work closely with BHASO's, MCO's and Crisis stabilization centers to create a referral flow and coordination of services.

This continued support for a PATH peer counselor on the PATH teams will allow agencies to expand needed outreach and engagement efforts. The proposed funds will enhance the quality of program delivery and engagement and expand critical crisis resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

The intention of Homeless outreach services is to reach individuals who are not currently engaged in treatment, services and who are potentially unable to navigate the system. The ability to have one additional peer outreach team member will allow these programs to broaden the current outreach and engage services to a primary focus of crises response.

Projects for Assistance in Transition from Homelessness (PATH) teams currently serve individuals experiencing homelessness and mental illness and BIPOC communities. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: MHAR-RSS14

Project Title: Operating Costs for a Housing Inventory/Estimator/Calculator **Proposed Budget:** \$10,000

Scope:

The Research and Data Analysis Division (RDA) within the Department of Social and Health Services (DSHS) completed a series of reports in 2012 examining the housing status of individuals following their exit from institutional or out-of-home care settings. More than one-quarter of all five study populations (individuals leaving Substance Use Treatment Facilities; State Department of Corrections Facilities; Foster Care; State Mental Hospitals and Juvenile Rehabilitation Facilities) experienced homelessness at some point over a 12-month follow-up period. This funding supports the online searchable tool based on various scenarios to connect individuals with behavioral health conditions to housing.

This searchable tool that will be housed on the Research and Data Analysis Pathways to Housing site will be used to help address the fact that almost 50 percent of Individuals leaving residential substance use treatment facilities became homeless within the year of discharge. Individuals exiting prison, foster care, State Mental Hospitals, and Juvenile Rehabilitation facilities were more likely to experience homelessness but as likely to obtain to permanent housing when they received housing assistance. Across the five study populations, the proportion of individuals in need of housing who received Homeless Management Information System (HIMS)-recorded assistance was highest for youth aging out of foster care (at 35 percent). Even though this report is dated, it is believed these relate to the population we intend to start with: individuals with behavioral health issues still exist and may even be more exacerbated with the COVID pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will provide timely information for individuals with behavioral health conditions to access housing services and resources.

The searchable housing tool will ensure individuals with Behavioral Health conditions and part of the BIPOC population will have access to housing services and resources.

Project #: MHAR-RSS16

Project Title: Supportive Housing Institute

Proposed Budget: \$150,000

Scope:

DBHR proposes to use the proprietary curriculum from the Corporation for Supportive Housing to increase the number of affordable housing development for individuals with serious mental illness or serious emotional disturbance. HCA-DBHR will contract with CSH to assist with the design and implementation of two Supportive Housing Institutes (the "Institute") for the State of Washington whose completion will coincide with the capital and operating fund cycles of both 2022 and 2023. Each Institute will take place over a five-month period and allow for up to eight project teams per Institute.

Each team will be required to include a SUD/MH service provider, developer, and operator (property manager) of a specific, proposed project. CSH will lead the teams through hands-on learning to take their projects from concept to fully developed project plans. Each Institute will produce projects that are well prepared for state and local funding and that align with the national Dimensions of Quality Supportive Housing, which include and supersede the fidelity indexes of SAMHSA, Pathways, and Watson HRM.

The HCA oversees the State's Medicaid benefits called Foundational Community Supports, which include supportive housing and supported employment services. Providers State-wide are expanding their delivery of these services to beneficiaries who are experiencing chronic homelessness, unnecessary institutionalization, and cycles of homelessness and system involvement, but scaling supportive housing itself remains constrained by a lack of supportive housing apartments. The HCA aims to build the capacity of mental health and substance use treatment providers to develop, operate, and/or form strong partnerships with other organizations to deliver new, high-quality supportive housing developments.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also increases experiences of trauma, co-occurring disorders, and increases chance of criminal justice interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

Foundational Community Supports utilizes the evidence-based practices of SAMSHA's Permanent Supportive Housing and Westat's individual placement and support. The principles of these evidence-based practices encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. These services also value and approach participants with equity, respect as well as cultural humility with the hope of promising outcomes.

Project #: BGCE-RSS19

Project Title: Cover Foundational Community Support (FCS) Services in Institution of Mental Disease (IMD) When Medicaid is Suspended

Proposed Budget: \$500,000

Scope:

The Division of Behavioral Health and Recovery proposes to utilize block grant funds to cover Foundational Community Support services for people transitioning out of Institution of Mental Disease (IMD) settings if the Medicaid isn't retroactively reconnected. The Foundational Community Support (FCS) program assists eligible individuals with complex health needs obtain and maintain stable housing

and can provide Foundational Community Support services within short-term Institution of Mental Disease (IMD) settings with housing assessments and begin the housing acquisition process prior to discharge. These newly added services to Foundational Community Support will include coaching, advocacy, information and referral, linking and coordinating, and ongoing supports that they may not otherwise have access to.

The program offers an array of transition/pre-tenancy and tenancy-sustaining supports that have been effective in improving housing stability, health and employment outcomes for high need Medicaid beneficiaries. linking and coordinating, and ongoing supports that they may not otherwise have access to. Many of these individuals have complex health profiles and face multiple housing related barriers to effectively engaging with health care systems and managing their own plan of care to achieve improved health and wellness. Foundational Community Support have reduced the frequent use of emergency department and inpatient care, addressed significant gaps in connections to care, addressed homelessness, and now can help to facilitate timely, successful transitions from institutional settings to integration in community placements. Anticipated Outcomes:

- Effectively target interventions to eligible individuals in residential treatment settings;
- Streamline and standardize transition and tenancy-sustaining services for individuals exiting residential treatment across agencies and systems;
- optimize and braid all available funding to fill gaps;
- reduce Substance Use Disorder/Opioid Use Disorder (SUD/OD) related deaths;
- improve Substance Use Disorder system capacity; and
- improve quality of care

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is no other mechanism to reimburse Foundational Community Support providers if the individuals Medicaid is not active at the time of authorization. The Health Care Authority has taken steps to attempt to mitigate this by providing Foundational Community Support providers access to Provider One to check Medicaid eligibility. This however is not a perfect solution and there are times when Foundational Community Support providers go unpaid.

The Foundational Community Support program is based on the evidence-based practices (EBP) of Permanent Supportive Housing (PSH) and Individual Placement and Support (IPS). The principles of these Evidence-Based Practices encompass equity and racial justice through the promotion of choice, flexible voluntary services, and access.

Project #: BGCE-RSS24

Project Title: Peer Pathfinders Transition from Incarceration Pilot

Proposed Budget: \$790,000

Scope:

This funding will continue support for a Certified Peer Counselor to up to five existing BH-ASO contracts for jail transition services. Adding a Certified Peer Counselor to existing jail transition services teams will increase the level of services being provided, by having a CPC connect with the individuals while they are still in jail and helping them with transition to the community. The certified peer counselor will work

with individuals diagnosed with a serious mental illness, linking them to behavioral health services, including co-occurring treatment, Foundational Community Support (FCS), and other applicable services.

Multiple studies support the fact that Peer support services has significant impacts on quality of life, reducing substance use, and improving positive social supports. Studies have also identified common elements of peer support, suggesting possible processes that underlie effective peer support. Peer services include shared experiences, role modelling, and positive social support. All of which are suggested to be vital aspect of peer support and moderate positive life changes. By adding a certified peer counselor to existing Jail Transition services allows for access to these vital services for individuals with SMI and co-occurring health conditions, reducing likelihood for further court involvement. Impacts that are likely to occur if this project is not approved included recidivism because the individual was not provided the needed services during their jail transition.

Addressing State Needs and Gaps, Including Gaps in Equity:

People exiting jails are more likely to be successful when they are able to connect and engage in services in their communities upon release. Currently in some parts of the state jail transition services are only reaching jail populations a few times a month. By adding a Certified Peer Counselor to existing jail transition services, individuals who are in need of extra support in accessing community-based services can be offered the support of a peer. These certified peer counselors would focus on linking individuals to behavioral health services, including co-occurring treatment, housing and employment, and community resources.

A disproportionate number of individuals of color are represented in our criminal court system and they experience greater barriers in accessing healthcare and community behavioral healthcare. This problem is greater amplified the further away you move from urban settings and locations in which more services are available. By adding the support of a Certified Peer Counselor to existing jail transition services, this will increase the likelihood of individuals being able to overcome some of these barriers.

Project #: BGCE-RSS25

Project Title: Add Co-Occurring Peer to F-HARPS

Proposed Budget: \$400,000

Scope:

These additional funds would continue support for a certified peer counselor for each Forensic HARPS team in the phase 1 regions, originally funded through the Block Grant Covid Supplemental award. With this additional staff person, the teams would be able to increase caseload capacity. This position would also allow the Forensic HARPS teams to serve individuals diagnosed with serious mental illness or co-occurring.

This project is critical because it will increase the capacity of the teams to serve more eligible individuals through the Forensic HARPS program, an element of the Trueblood Settlement. Housing access, support, and short-term subsidies increase an individual's opportunity for recovery. Housing is a basic need that reduces the likelihood of recidivism in the criminal court system. If this funding is not approved, the Forensic HARPS teams will not be able to serve all those who are eligible and in need of this service.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Forensic HARPS teams have short-term housing subsidy dollars to assist participants in obtaining and maintaining housing. The amount of subsidy dollars allocated to each team is greater than what the current staffing model allows them to spend. With this additional staff person, the Forensic HARPS teams will be able to fully utilize the subsidy dollars allocated to them. Funding Forensic HARPS teams is cost effective because it diverts individuals with serious behavioral health conditions into receiving the services, they need instead of being arrested or hospitalized. Supportive housing reduces inpatient hospitalization, incarceration and engagement in outpatient treatment increases when individuals are successfully housed (RDA, FCS preliminary outcomes 2020).

Helping individuals obtain and maintain housing of their choice helps them be more successful in treatment. Forensic HARPS teams are trained in leveraging all community resources once an individual exits jail or an institutional setting, but the 'bridge subsidy' is still needed in order to assist individuals exit jail as quickly as possible.

A disproportionate number of individuals of color are represented in our criminal court system. Many of these individuals experience significant barriers in accessing safe and affordable housing. WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. People with trauma, a history of homelessness, and co-occurring disorders have an increased likelihood of being involved in the criminal court system. Helping individuals find and maintain housing of their choice, and obtain wanted services, especially during an increased time of hardship such as COVID-19 is our states responsibility.

Project #: BGCE-RSS36

Project Title: Funding for SSI/SSDI, Outreach, Access, and Recovery (SOAR) Leads

Proposed Budget: \$500,000

Scope:

SSI/SSDI Outreach Access and Recovery (SOAR) is a proven effective model to increase access to governmental benefits. This project would create a SOAR Lead Position in multiple regions/counties (scalable). SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads hold local steering committee meetings, lead SSI/SSDI, Outreach, Access and Recovery (SOAR) online course training cohorts and conduct half-day SSI/SSDI, Outreach, Access and Recovery (SOAR) online course review sessions. SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads will also be mentoring individuals who complete the SSI/SSDI, Outreach, Access and Recovery (SOAR) online course and reporting on outcomes.

This will provide increased access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a serious mental illness. Access to these benefits will help individuals stabilize their housing and health.

Addressing State Needs and Gaps, Including Gaps in Equity:

Many unhoused individuals qualify for disability benefits but have a difficult time getting through the application process. With an SSI/SSDI, Outreach, Access Recovery (SOAR) Representative assisting with the application process, individuals are approved more often and more quickly. Most landlords require some kind of monthly income, this will help provide that and allow more individuals to obtain housing.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS41

Project Title: Enhance Mobile Crisis Teams with CPCs

Proposed Budget: \$1,909,000

Scope:

HCA will build upon the Transformation Transfer Initiative (TTI) crisis services continuing education curriculum for Certified Peer Counselors by piloting enhancements to mobile crisis teams by adding Certified Peer Counselors to existing teams. Funds will be issued to BH-ASOs to expand Mobile Crisis Response services serving those diagnosed with SMI/SED.

This project will provide enhance mobile crisis services by continuing support for certified peer counselors in Washington State. The intended outcome is to increase the engagement and outreach of MCR teams to include certified peer counselors to even more effectively support the peers they serve in crisis settings.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. Expanding mobile crisis services to include Certified Peer Counselors will better support people as Washington expands peer services in crisis settings.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote DEI and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Tribal Projects Detail

Project #: MHAR-TRB1

Project Title: TARGET (database) Replacement

Proposed Budget: \$200,000

Scope:

Based on a pilot to work with a Tribe that currently has EPIC to develop a mechanism to automatically upload SAMHSA-required data to HCA's behavioral health data store, with minimal double entry of data, this project will support the expansion and maintenance of this pilot to other Tribes across the state. This project will offer funding to maintain the behavioral health data system that will replace the previously used TARGET system.

This project will ensure that there is maintenance for the data system that will support the collection of SAMHSA-required data. As the pilot will help HCA to identify if we can use an existing EHR to build the necessary system to meet the needs of the Tribes and the state in SUD and mental health data collection for our reporting to our federal partners/funders and the state legislature, this project will maintain these efforts and address any system improvements needed along with the evolving landscape for behavioral health data collection and reporting.

Addressing State Needs and Gaps, Including Gaps in Equity:

Tribes requested a solution for the TARGET replacement in 2016. Providing funding resources to maintain and improve data collection for Tribes will address a long-time gap for Tribal communities in SUD and mental health data collection in the new integrated health care environment.

This project will systemically improve data reporting and surveillance of AI/AN communities to better address any health disparities. Data is very important in identifying needs and strengths in BIPOC communities.

Project #: MHAR-TRB3

Project Title: Funding to Tribes and Urban Indian Health Organizations

Proposed Budget: \$1,460,114

Scope:

The Health Care Authority will provide contracts to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver needed behavioral health, mental health services for individuals with SMI/SED and substance use disorder prevention, treatment, OUD intervention and recovery supports services within their Tribal communities. Tribes will submit a plan to implement recommended services as outlined in the NOA and allowed within the SABG/MHBG regulations. Additional funds for Tribes will be divided evenly between the Tribes and Urban Indian Health Programs (UIHP) (Native Project & SIHB). These funds will begin on March 2023 - Sept 2025 and may be an extension of the Tribe's and UIHP's COVID Enhancement projects to ensure a full recovery from the impacts of the COVID pandemic.

This project is important because AI/AN and Tribal communities have been greatly affected by the COVID pandemic and the various Tribal and State Stay at Home Orders. Tribes are identifying ways to maintain some of their BH program in a virtual and semi/virtual environment. Due to the pandemic, Tribes are stating that the individuals in their communities are struggling with social isolation and a lack of treatment services due to the pandemic. There has also been limited cultural activities available for Tribal communities due to the pandemic. The historic annual Canoe Journey was canceled two years in a row with very limited ability to implement cultural programs across all Tribal communities. These funds will support the Tribe's and UIHP's ability to address any gaps and needs in their behavioral health services and increase support individuals that may have lingering behavioral health impacts due to the COVID 19 pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

Department of Health (DOH) reported that overdose rates have gone up over 154% during the first 6 months of the pandemic and is the highest of other communities by race/ethnicity. The statewide increase overall is 30%. The Health Care Authority needs to continue to provide resources to Tribal communities to address those diagnosed with SMI or SED for American Indian/Alaskan Native (AI/AN) in WA. Providing direct funding to Tribes and Urban Indian Health Programs (UIHPs) also honors our government-to-government relationships by partnering with Tribes to serve American Indian/Alaskan Native WA State residents.

This project directly supports Diversity, Equity and Inclusion (DEI) by providing needed services to the American Indian/Alaskan Native (AI/AN) population in providing culturally appropriate services. This also honors our unique Government-to-Government (G2G) relationships with Tribal governments and our partnership with Urban Indian Health Programs (UIHPs).

Crisis Services:

Tribes and Urban Indian Health Programs (UIHPs) may provide crisis services with these funds. The Health Care Authority will pass down National Guidelines to Tribes to provide guidance on best practices for crisis services.

Crisis Set-Aside Projects Detail

Project #: MHAR-ASO2

Project Title: Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding for Crisis Services

Proposed Budget: \$3,320,228

Scope:

Funding directed to the Behavioral Health Administrative Service Organizations (BH-ASO's) will support their respective crisis provider networks enhancing the provision of comprehensive community mental

health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. Funding will be used to enhance existing Crisis Services provided 24 hours a day, seven days a week including crisis call line, evaluation and treatment services for Individual's ineligible for Medicaid, including involuntary inpatient services, voluntary inpatient services, crisis stabilization services, Employment and Training (E&T) services, and services for the priority populations defined per Contract. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retainment issues that have increased throughout the behavioral health delivery system during the pandemic. All funded crisis workers will be required to be trained in trauma informed care, de-escalation techniques and the fundamentals of harm reduction.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that policies and procedures have had different negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation. Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based mental health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health and substance use crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments; and strategies to reduce the fragmentation of mental health care.

Technology Infrastructure Projects Detail

Project #: MHAR-TEC1

Project Title: Clinical Data Repository

Proposed Budget: \$325,000

Scope:

This funding request is to support technological enhancements to the CDR that will allow retention of historical clinical data, including MH/SUD data, as well as implementation of an analytic enclave environment. This solution will allow authorized users, including researchers, evaluators, state staff, clinicians and others to access protected health information in a secure environment in order for them to conduct their research and analyses, without the need for these data to leave the CDR secure environment. This will support programmatic enhancements, overall program governance, and analytics in order to achieve meaningful results and support other key efforts such as Value Based Purchasing, Health Care Transformation and Health Care Cost/Quality Transparency.

The current Medicaid CDR was established several years ago. There is now a need to enhance the current CDR and define a strategic vision focused on clinical quality and outcome analytics, total cost of care analytics and care coordination functions especially focused on MH/SUD clients. Washington's CDR presents a unique opportunity to develop a true clinical data warehouse that is leveraged in conjunction with other State data assets such as the All-Payer Claims Database (APCD), the Health Information Exchange (HIE), Public Health disease registries and others, to generate true total cost of care and care quality/outcome analytics to inform research, policy and health system transformation.

Addressing State Needs and Gaps, Including Gaps in Equity:

Care coordination for MH/SUD clients is greatly impeded currently by a lack of seamless data exchange between providers. The CDR is a critical data asset which has the capabilities to help bridge this gap. This investment will significantly enhance the technological ability of this tool to enable appropriate and secure data sharing amongst those who need it in order to better serve the MH/SUD clients in Washington.

Medicaid clients who need MH/SUD services are amongst the most vulnerable populations in our care. As stated above, care coordination for MH/SUD clients is greatly impeded currently by a lack of seamless data exchange between providers. The CDR is a critical data asset which has the capabilities to help bridge this gap and help enhance equitable access to information about clients to their providers. This investment will significantly enhance the technological ability of this tool to enable appropriate and secure data sharing amongst those who need it in order to better serve the MH/SUD clients in Washington.

Health IT Infrastructure

The Clinical Data Repository as implemented in the state of Washington is compliant with health information technology standards and implementation specifications as identified in 45 CFR 170, Subpart B.

Project #: MHAR-TEC2

Project Title: Consent Management Solution

Proposed Budget: \$1,300,000

Scope:

The electronic consent management solution, which has been approved by Washington State HHS agencies, will be a key foundational investment in the state's health information exchange infrastructure and will enable meaningful, seamless exchange of protected and sensitive BH and PH information amongst those who are authorized to receive it in order to deliver services to Washingtonians.

Every initiative to support Behavioral Health Integration requires Behavioral Health (BH) and Physical Health (PH) data to be seamlessly shared amongst clinicians, and across the care continuum. Care coordination, case management, population health and even public health, as evidenced during this past year, are highly dependent on this seamless exchange of information. In addition to direct care clinicians, others in the care system such as care coordinators, case managers, managed care organizations, public health entities and others also need access to such data in order to be able to fulfill their respective missions. Lack of a standardized, centralized consent management solution has presented a significant barrier to realizing true BH-PH integration.

Addressing State Needs and Gaps, Including Gaps in Equity:

Care coordination for MH/SUD clients is greatly impeded currently by a lack of seamless data exchange between providers. A centralized consent management solution is a critical investment which will provide the capabilities to help bridge this gap. This investment will significantly enhance the technological ability that enables appropriate and secure data sharing amongst those who need it in order to better serve the MH/SUD clients in Washington.

Medicaid clients who need MH/SUD services are amongst the most vulnerable populations in our care. As stated above, care coordination for MH/SUD clients is greatly impeded currently by a lack of seamless data exchange between providers. A centralized consent management solution is a critical investment which will provide the capabilities to help bridge this gap and help enhance equitable access to information about clients to their providers. This investment will significantly enhance the technological ability to enable appropriate and secure data sharing amongst those who need it in order to better serve the MH/SUD clients in Washington.

Health IT Infrastructure

The consent management solution will meet health information technology standards and implementation specifications as identified in 45 CFR 170, Subpart B. Specifically, the consent management solution will be interoperable with ONC certified Electronic Health Record (EHR) systems and will use HL7 FHIR standards for secure data exchange between systems.

Project #: SAAR-TEC3

Project Title: Statewide Bed Registry

Proposed Budget: \$1,414,478

Scope:

This project will develop and implement a statewide bed registry to track capacity and real-time bed availability for psychiatric hospital beds, freestanding evaluation and treatment center beds, Secure Withdrawal Management and Stabilization Beds, crisis triage/stabilization beds, and substance use disorder residential treatment beds. The registry is intended to include both adult and youth/child beds.

Contracted resources will be utilized to implement this new solution, with management of maintenance and operations to be supported by existing staff resources.

The lack of a statewide bed registry has been a long-standing problem within the state. The need has been discussed in multiple work groups. This would include the legislative BHRST group and the ITA Work Group required by SB 5720. Both these workgroups have included stakeholder and consumer testimony on how difficult it is for a crisis worker, an individual or family member to find an available treatment bed. Currently, without a bed registry, multiple facilities have to be called to see if they provide the appropriate treatment services and to see if they have any vacant beds. Sometimes this process involves calling up to 20 facilities. Implementation of a registry will make it significantly easier to locate beds and access care. If this is not approved, crisis workers, individuals and families will continue to face obstacles in accessing critical care.

Addressing State Needs and Gaps, Including Gaps in Equity:

Ready access to mental health and substance use disorder treatment beds will benefit all populations. We know that due to social determinants of health and historical trauma, there is a disproportionate need for care for BIPOC individuals. That care should be readily available.

Health IT Infrastructure

The Statewide Bed Registry in the state of Washington will be compliant with health information technology standards and implementation specifications as identified in 45 CFR 170, Subpart B.

Washington

American Rescue Plan Act Funding Work Plan for FY22-25

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

Center for Mental Health Services
Division of State and Community Systems Development

Mental Health Block Grant APRA Funding Plan

WA State Summary

The COVID-19 pandemic has had a significant impact on people with Serious Mental Illness (SMI) and Serious Emotional Disturbance (SED) in Washington State. During the first half of 2019, 8.2% of adults over 18 years of age had symptoms of anxiety disorder and 6.6% had symptoms of depressive disorder. By comparison, in the most recent Household Pulse Survey from the Centers for Disease Control examining trends from February 17, 2021, to March 1, 2021, this prevalence quadrupled to 33.4% for anxiety and 27.7% for depression (in Washington state, rates were slightly higher with 34.2% for anxiety, 14th highest of the 50 states, and 27.8% for depression, 23rd highest of the 50 states). The age group with the highest prevalence rates nationally is 18–29-year-olds (47.2% reporting anxiety, and 42.2% reporting depression). The devastating impacts of the COVID-19 pandemic have clearly impacted young adults' mental health and substance use (a population already at high risk).

As the state and nation emerge from early Phases of the pandemic, the resulting impacts of the last year are a salient concern. People face potentially new obstacles such as continued mental health issues, overcoming the potential disruptions in school, work, and finances, and re-engaging in social life with continued recommendations from the CDC and local health departments (e.g., mask mandates). This is a critical time to address potential harms and to encourage engagement in both adaptive coping behaviors and unique strategies of social engagement within current public health guidelines to reduce high-risk substance use and worsening mental health symptoms, in both adults and youth.

HCA's Division of Behavioral Health and Recovery has reviewed the *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* and allocated a percentage of the total potential American Rescue Plan Act (ARPA) funding to address principles focused on recovery needs, support for the behavioral health workforce, particularly of Peers and Recovery Support Peers, and trauma-informed treatment services. Our intention is to use the ARPA funding to sustain projects originally funded through the Covid Supplemental award through September 2025, which will result in some of our contracts not being executed until March 2023. In addition to extending support for those projects, we are also adding in new funding for suicide prevention and technology infrastructure. The budget summary, on the following pages, provides the detailed amounts allocated across the continuum of behavioral health services through a wide variety of projects, treatment funds provided through our Behavioral Health Administrative Service Organizations (BH-ASOs) and Tribes. The Washington Health Care Authority respectfully submits the proposals you will find in the pages to follow.

As part of our effort to seek stakeholder input, the Behavioral Health Advisory Council co-hosted a meeting with the Health Care Authority to invite input from various partners and representatives from across the state's behavioral health system (from Peers to school districts, as well as counties, managed care organizations and others) on priorities for the Covid-19 Supplemental funding. Input on the proposals was received at the end of the event, which helped to inform the direction, as well as solidify the allocations to each section. We are utilizing the input received from this to guide us in our investments using the ARPA funding as well. The Health Care Authority may also require some flexibility to move allocations from one proposal, to another, within those in this application, in the event a

particular proposal is particularly successful and requires funding allocation from another proposal which may not require the entire allocation presented in this application. Additionally, the Washington Legislature will require the review and approval of our workplan in the 2023 Legislative session, which may create the need to shift funding based on their decisions at that time.

Within the budget summary below, you will find the proposed project titles, a brief description and number for each project under the sections of Prevention, First Episode Psychosis, Treatment, Recovery Support Services, Tribal, Crisis Services and Technology Infrastructure. In the pages that follow, a longer project narrative will include the project title, budgeted amount, a description, or scope of work summary, as well as a narrative of how the project addresses state needs and gaps, especially gaps in equity.

WA is grateful to SAMHSA for the opportunity to apply for the ARPA funds, as this has been an unprecedented year of extreme stressors to the most vulnerable among us, and the funding will undoubtedly support those persons at greatest risk, as well as those who seek support in treatment and ongoing recovery.

Project List and Budget Table

FEP Set-Aside			
Project #	Project Title	Project Description	Proposed Budget
MHAR-CYF1	Rural and AI/AN Evidence Based Coordinated Specialty Care for FEP	Develop and adapt evidence based coordinated specialty care programs for FEP to meet the needs of rural, frontier and AI/AN communities.	\$3,984,273
Total FEP Set-Aside			\$3,984,273
Treatment			
Children, Youth and Family Treatment Funding			
Project #	Project Title	Project Description	Proposed Budget
MHAR-CYF2	Developing Wraparound and Intensive Services (WiSe) Workforce Support	Developing Wraparound and Intensive Service (WiSe) workforce to support youth with SED who have Intellectual Disabilities/Developmental Disabilities (including Autism Spectrum Disorder (ASD)).	\$600,000
MHAR-CYF5	Trauma Focused Cognitive Behavioral Therapy Training	Trauma Focused Cognitive Behavioral Therapy (CBT) Training for clinicians serving children and youth returning to school as part of the triage process post screening.	\$376,671

MHAR-CYF5	Regional Response Teams	Regional Response Teams are intended as the interface with the TF-CBT program and also manage the needs of youth “stuck” on the queue awaiting placement.	
Adult Treatment Funding			
MHAR-MHA1	Cognitive Behavioral Therapy for Psychosis	Expansion of current contract to deliver Cognitive Behavioral Therapy for Psychosis to a cohort of clinicians who are serving people on 90/180 involuntary civil commitment orders.	\$130,000
MHAR-MHA3	Mental Health Specialist Training	Provide training via a 100-hour course for Mental Health (MH) professionals to secure credentials to become an Older Adult Mental Health Specialist, Intellectual Disabilities /Developmental Disabilities (ID/DD) Mental Health Specialist, and Ethnic Minority Mental Health Specialist.	\$396,671
BH-ASO Treatment Funding			
MHAR-ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding	The community mental health services provided include but are not limited to outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, residents of the service areas who have been discharged from inpatient treatment at a mental health facility, day treatment or other partial hospitalization services, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, or ready for discharge from inpatient psychiatric care, and individuals residing in rural areas.	\$10,066,183
Total Treatment			\$11,569,525
Recovery Support Services			
Project #	Project Title	Project Description	Proposed Budget

MHAR-RSS1	Participant Support Funds- Housing and Recovery through Peer Services (HARPS) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$50,000
MHAR-RSS2	Participant Support Funds- Projects for Assistance in Transition from Homelessness (PATH) teams	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$140,000
MHAR-RSS3	Participant support Funds - Peer Bridger	Mental Health Block Grant (MHBG) funds could be used to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination with primary care, case management etc.	\$100,000
MHAR-RSS12	Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams	Targeted peer outreach on Project for Assistance in Transition from Homelessness (PATH) teams focusing on a by-name list of individuals who have had multiple contacts with crisis system.	\$1,759,433
MHAR-RSS14	Operating costs for a housing inventory/estimator/calculator	Provide timely information for individuals with behavioral health conditions to access housing services and resources.	\$10,000
MHAR-RSS16	Supportive Housing Institute	Corporation for Supportive Housing (CSH) curriculum to increase the number of affordable housing development for individuals with mental health and substance use disorders. Note: Also funded with SABG ARPA for co-occurring.	\$150,000
MHAR-RSS19	Cover Foundational Community Support Services in Institution for Mental Disease (IMD) when Medicaid is Suspended	Utilize block grant funds that would cover Foundational Community Support services for people transitioning out of Institution for Mental Disease (IMD) settings if Medicaid does not get retroactively reconnected.	\$500,000

MHAR-RSS24	Peer Pathfinders Transition from Incarceration Pilot	Enhance jail transition programs with SUD peers services to individuals who upon release will be homeless. SUD Peer Services begin prior to release to establish relationship and upon release to support the transition to needed services. Note: Also funded with SABG ARPA for co-occurring.	\$790,000
MHAR-RSS25	Add Co-Occurring Peer to Forensic-Housing Housing and Recovery through Peer (F-HARPS) Services	Add 1 peer to each of the four Forensic-Housing Housing and Recovery through Peer Services (F-HARPS) in Phase I regions.	\$400,000
MHAR-RSS36	Funding for SSI/SSDI Outreach, Access, and Recovery (SOAR) Leads	Helping individuals with the creation of a Supplemental Security Income/Social Security Disability Insurance (SSI/SSDI) outreach access and recovery community coordinators.	\$500,000
MHAR-RSS41	Enhance Mobile Crisis Teams with CPCs	Pilot enhancements to mobile crisis teams by adding CPCs to existing teams.	\$1,909,000
Total Recovery Support Services			\$6,308,433
Tribal			
Project #	Project Title	Project Description	Proposed Budget
MHAR-TRB1	TARGET (database) Replacement	TARGET replacement program for SUD and mental health data. Note: Also funded with SABG ARPA for co-occurring.	\$200,000
MHAR-TRB3	Funding to Tribes and Urban Indian Health Organizations	Provide funding to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver treatment for individuals diagnosed with SMI/SED, prevention, treatment, and recovery support services within their Tribal communities.	\$1,460,114
Total Tribal			\$1,660,114
Crisis Set-Aside			
Project #	Project Title	Project Description	Proposed Budget

MHAR-ASO2	Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding - Crisis Services	Services include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responders (DCR) services.	\$3,320,228
Total Crisis Set-Aside			\$3,320,228
Technology Infrastructure			
Project #	Project Title	Project Description	Proposed Budget
MHAR-TEC1	Clinical Data Repository	Support technological enhancements to the CDR that will allow retention of historical clinical data, including MH/SUD data, as well as implementation of an analytic enclave environment. Note: Also funded with SABG ARPA for co-occurring.	\$325,000
MHAR-TEC2	Consent Management Solution	Enable meaningful, seamless exchange of protected and sensitive BH and PH information amongst those who are authorized to receive it in order to deliver services to Washingtonians.	\$1,300,000
MHAR-TEC3	Statewide Bed Registry	Develop and implement a statewide bed registry to track capacity and real-time bed availability for psychiatric hospital beds, freestanding evaluation and treatment center beds, Secure Withdrawal Management and Stabilization Beds, crisis triage/stabilization beds, and substance use disorder residential treatment beds. Note: Also funded with SABG ARPA for co-occurring.	\$1,414,478
Total Technology Infrastructure			\$3,039,478
TOTAL MHBG Covid Supplement Budget			
FEP Set-Aside			\$3,984,273
Treatment			\$13,229,639
Recovery Supports Services			\$6,308,433
Tribal			\$1,660,114
Crisis Set-Aside			\$3,320,228
Technology Infrastructure			\$3,039,478

	Administrative	\$1,660,114
	Total Budget	\$33,202,279

First Episode Psychosis Project Detail

Project #: MHAR-CYF1

Project Title: Rural and AI/AN Evidence Based Coordinated Specialty Care for FEP

Proposed Budget: \$3,984,273

Scope:

This additional project amount would be to develop and adapt evidence based coordinated specialty care (CSC) programs for first episode psychosis (FEP) to meet the needs of rural, frontier, AI/AN communities, and other special populations; with the necessary support to operationalize the projects in a timely manner. The project would be to help to develop a rural and /or Tribal New Journeys/CSC model, to evaluate it, and broadly disseminate the results to inform future program development. This model can expand to other specific populations as the work advances. Other states are also interested in figuring out how to develop CSC services in rural areas and Tribal communities and other specific populations. There could be great value in collaborating with partners in other states on this (they would fund their own program development) and could help to define rural and AI/AN CSC in other parts of the U.S.

This work is critical to accomplish the legislative mandate in SSSB 5903 requiring statewide expansion of treatment for FEP. Specialized knowledge and adaptation are essential to meet the unique needs of sparsely populated regions and minority communities in order to achieve the goal of decreasing the duration of untreated psychosis. Considering the magnitude of the impact of schizophrenia, interventions designed to treat the disorder effectively at the earliest possible point (e.g., during the first episode of psychosis) have the potential to improve its long-term trajectory, improve outcomes, improve lives, save lives and save health care dollars and to reduce the health care burden of the illness. The longer a person goes untreated, the more severe and chronic their symptoms become, often resulting in decreased functioning and other negative outcomes over their lifetime.

Addressing State Needs and Gaps, Including Gaps in Equity:

Initial examination of 2018 Medicaid data indicate that extra support is needed to ensure that intervention with first episode is equally available in rural geographical areas and in AI/AN communities. The data suggest there are existing geographical disparities and AI/AN disproportionality. The Washington State Legislature, Children's & Youth Behavioral Health work group (CYBWHG) and SAMSHA have all prioritized early identification and intervention for psychosis. This is so screening and early

identification of psychosis among adolescents and young adults will become a universal health care practice, and evidence-based recovery interventions will be available to those who need them.

Treatment Projects Detail

Children, Youth and Family

Project #: MHAR-CYF2

Project Title: Developing Wraparound and Intensive Services (WISe) Workforce Support

Proposed Budget: \$600,000

Scope:

Expansion of Workforce & Enhancing Local Care Networks to support Youth with Intellectual or Developmental Disabilities including Autism Spectrum Disorder.

Based on the initial model, identify additional WISe behavioral health agencies each year to plan and implement the project informed by local needs with logistical oversight provided the WISe Workforce Collaborative/En Route. Develop glide path for more expansive reach of focused special population services. A training component will be provided by Seattle Children's Autism Center and offered to additional BH agencies. The proposed RUBI training model will include:

- (1) An initial 16-hour workshop attended by all WISe team providers;
- (2) 20 weeks of ongoing consultation with the WISe team mental health therapist
- (3) Fidelity review of WISe therapist implementation of RUBI sessions

Agencies selected will have been involved in the HCA and DDA convened WISe and ID/DD and ASD workgroup or Project Echo sessions. This allows the project to build more directly on the knowledge and efforts already in process.

The three lead agencies will dedicate a portion of a staff time to participate in developing the specialty team model, attend training, learning collaboratives and consultation. Lead sites will also convene community partners to plan for enhancing their local care network to support youth with ID/DD and ASD.

During COVID the increased need of trained staff to provide stabilization support for youth in WISe with ID/DD including ASD has become apparent. The concern identifying the need for additional training has

been expressed by caregivers, behavioral health agency staff and allied system partners. Our behavioral health workforce is often times generalists by education and don't have the training to best support youth with ASD and their families. This funding would provide the training support and consultation to five behavioral health agencies as well as enhance community coordination in three regions for youth enrolled in WISE with ID/DD including ASD.

Wraparound with Intensive Services (WISE) provides intensive home and community based mental health services to Medicaid eligible children and youth, in compliance with Title XIX of the federal Social Security Act. WISE is available for children and youth 20 years of age or younger who have a serious mental illness.

To receive WISE a child or youth is 1) Medicaid eligible, 2) has a mental health diagnosis and 3) meets the WISE screening algorithm. The WISE screen is to help determine if the youth needs this intensive level of outpatient care.

By design, WISE is a service delivery model for children and youth with the most complex mental health challenges in Washington state. WISE provides individualized, culturally competent services that strive to keep youth with intense mental health needs safe in their own homes and communities, while reducing unnecessary hospitalizations. WISE offers a higher level of care through these core components:

- The Time and Location of services: WISE is community-based. Services are provided in locations and at times that work best for the youth and family, such as in the family home and on evenings and weekends.
- Team-based Approach: Each WISE team includes youth, family members, a WISE care coordinator, a therapist, a Certified Peer Counselor, includes natural supports and members from other child-serving systems when they are involved in a youth's life.
- Help during a crisis: Youth and families have access to crisis services any time of the day, 365 days a year. Youth receive services by individuals who know the youth and family's needs and circumstances, as well as their current crisis plan.

Intensive services provided in WISE include but are not limited to:

- Individual treatment services
- Family therapy services
- Psychiatric medication services
- Crisis mental health services—Outreach services
- Recovery support—Wraparound facilitation services
- Peer support services

References:

- The program, policy and Procedure manual can be found here [WISE Manual](#) and the WISE screening algorithm is available on page 75
- WISE meets the criteria established in the Children's Mental Health Lawsuit under obligations set forth in the [T.R. Settlement Agreement](#)
- [HCA WISE webpage](#)

Addressing State Needs and Gaps, Including Gaps in Equity:

Provides workforce training and development to address the need in providing co-occurring services for youth with ID/DD including ASD. Also provides funding for community coordination and input from youth, families and system partners.

The community coordination and development of this project would include outreach to BIPOC communities to participate and provide insight to specific community needs.

Project #: MHAR-CYF5

Project Title: Trauma Focused Cognitive Behavioral Therapy Training **Proposed Budget:** \$376,671

Scope:

Continue to provide training in TF-CBT to clinicians serving children and youth returning to school as part of the triage process post screening as a part of the recommended DOH fast response plan to help meet the needs of children and youth returning to school following the Governor's proclamation that in person options are required as of April 1, 2021. This will allow clinicians to continue to serve youth who indicate trauma exposure in the screening process (SED) following the pandemic to support increased access to necessary mental health supports. This will advance the Sonoma model and further enhance the clinical interventions available to children and youth across WA.

The Governor issued a proclamation that in person options be available across WA as of April 1, 2021. The potentially unmet needs of children and youth throughout the pandemic regarding mental health impact are expected to surface as children youth and families begin the transition to in person education. This proposal meets an identified need, and the timeline will ensure that trauma informed clinical interventions will be available to children and youth as transition back to school and acclimate to new norms.

Addressing State Needs and Gaps, Including Gaps in Equity:

The workforce serving children youth and families across Washington are dedicated to the age group and the developmentally appropriate interventions needed. This training further supports them in an evidence-based response to the expected wave of trauma exposure from impacts of the pandemic, to support and serve with resilience and strength based approaches and supports in pushing back compassion fatigue in ensuring they have the tools they need to feel effective in their work, resulting in resilient communities.

Efforts will be made to ensure training is offered to diverse clinician groups including BIPOC and LGBTQ+ clinician groups.

Project Title: Regional response teams

Proposed Budget: \$1,660,114

The regional response teams are intended to be the backbone all the initiatives at the regional level. They will be clinical and can manage referrals from schools, Emergency Departments and Primary Care Physicians. They are intended as the interface with the TF-CBT program and also to manage the needs of youth 'stuck' on the queue awaiting placement or solutions to their need for acute services. The team will also track local data and understand access issues at the regional level and support transitions of youth after crisis intervention,

The Governor issued a proclamation that in person options be available across WA as of April 1, 2021. The potentially unmet needs of children and youth throughout the pandemic regarding mental health impact are expected to surface as children youth and families begin the transition to in person education. This proposal meets an identified need, and the timeline will ensure that trauma informed clinical interventions will be available to children and youth as transition back to school and acclimate to new norms

Addressing State Needs and Gaps, Including Gaps in Equity:

The workforce serving children youth and families across Washington are dedicated to the age group and the developmentally appropriate interventions needed. Regional response teams will further support schools in linking students to appropriate tier three services, triage youth across the region to support the right services at the right time and support families in the transition periods to further stabilize the family unit and reduce trauma exposure from impacts of the pandemic, to support and serve with resilience and strength-based approaches and supports. Additionally, with regional response teams in place tracking access, stuck points in access, and availability of services policy makers will have real time information on what is needed where to further support the system infrastructure and reducing workforce burnout in a very difficult and long COVID response, resulting in healthier and resilient communities.

Adult Treatment

Project #: MHAR-MHA1

Project Title: Cognitive Behavioral Therapy for Psychosis

Proposed Budget: \$130,000

Scope:

This project will continue to enhance the workforce serving individuals with psychosis by delivering Cognitive Behavioral Therapy for Psychosis training and technical assistance to a cohort of outpatient and inpatient clinicians from selected contracted community-based sites who are serving people receiving 90/180-day involuntary civil commitment orders. This EBP helps people living with psychosis achieve a level of self-management that has shown great success, supporting individuals and their families in the community.

Training outpatient behavioral health agency staff and their locally corresponding contracted long term civil commitment sites in an appropriate EBP should assist this population in better managing their symptoms and reduce their need for further involuntary or inpatient treatment.

Addressing State Needs and Gaps, Including Gaps in Equity:

Training on CBT for Psychosis will help empower individuals with psychosis to better manage symptoms that interfere with their ability to live their lives in the community. The BH workforce needs enhanced tools to treat psychosis beyond simply medication alone and this EBP is targeted to the needs of a population that traditionally does not receive therapy as many clinicians do not know about CBT for Psychosis and its success rate.

People living with psychosis experience much social isolation due to their symptoms. By providing them with greater skills to manage psychosis, this inequity will be better addressed. This enhancement will serve all populations living with psychosis, including members of BIPOC communities but is not a targeted outreach to them specifically.

Project #: MHAR-MHA3

Project Title: Mental Health Specialist Training

Proposed Budget: \$396,671

Scope:

Provide training via a 100-hour course for Mental Health Professionals to secure credential to become an Older Adult MH Specialist, Intellectual/Developmental Disabilities Mental Health Specialist, and Ethnic Minority Mental Health Specialist as defined in Washington's Rehab State Plan for Mental Health Outpatient treatment. Training curricula will focus on recognizing unique needs of these populations, clinical best practices, understanding of the community resources and partners when working with these populations, the role of the Mental Health Specialist, and how to provide clinical consultation, cultural humility, and other relevant information specific to each demographic.

The Division of Behavioral Health and Recovery has not sponsored MH Specialist academies for almost 10 years and as such, there are significant workforce shortages in specialists trained and credentialed to work with these populations. Each has their own unique needs or considerations that impact care and the BH workforce needs additional training and support in order to meet these needs.

Addressing State Needs and Gaps, Including Gaps in Equity:

With a fast-growing aging population, the need for MHPs trained and sufficiently skilled to work with older adults is more critical than ever. The current workforce requires specialized skills and knowledge to better support BIPOC populations and people with intellectual or developmental disabilities. This workforce shortage must be addressed.

BIPOC communities, older adults, and people with Intellectual Disabilities/Developmental Disabilities must receive culturally appropriate services from clinicians with relevant education, experience, and skills. This is a matter of equity and parity.

BH-ASO Treatment Funding

Project #: MHAR-ASO2

Project Title: Behavioral Health Administrative Services Organization (BH-ASO) Treatment Funding

Proposed Budget: \$10,066,183

Scope:

Funding directed to the Behavioral Health Administrative Services Organizations (BH-ASO) will support their respective provider networks enhancing the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. This includes a regionally based system of care that includes mental health services to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities. Including increasing capacity of Designated Crisis Responder (DCR) and Tribal Designated Crisis Responder (DCR) services.

The community mental health services are provided to individuals with serious mental illness/serious emotional disturbance including specialized outpatient services for American Indian/Alaskan Native (AI/AN), children, and the elderly. Services provided include but are not limited to outpatient services for individuals who have been **discharged** from inpatient treatment, day treatment, psychosocial rehabilitation services, outreach to and services for individuals who are homeless, at risk of homelessness, and individuals residing in rural areas. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retainment issues that have increased throughout the behavioral health delivery system during the pandemic.

If funding were not approved the statewide behavioral health service delivery system will continue to face funding gaps, service delivery delays, and individuals diagnosed with Serious Mental Illness (SMI), or Serious Emotional Disturbance (SED) will be less likely to have opportunities to access services and function better in their communities experiencing an improved quality of life. Further, an opportunity to enhance and improve ongoing behavioral health system workforce recruitment and staff retention worsened by the pandemic will be missed.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support, and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals,

services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that policies and procedures have had negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation.

Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based behavioral health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments.

Recovery Support Services Projects Detail

Project #: MHAR-RSS1

Project Title: Participant Support Funds – Housing and Recovery through Peer Services (HARPS) Teams

Proposed Budget: \$50,000

Scope:

Adding additional support funds to each Housing and Recovery through Peer Support (HARPS contract to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination of other healthcare services and case management.

We expect the housing crisis and behavioral health crisis to intensify as eviction protections are lifted. The HARPS priority population is unable to earn wages while involved with inpatient treatment and is unlikely to have savings to secure housing upon discharge. Additionally, many participate intensive outpatient treatment which limits the amount of time to earn wages to afford housing, as well as other necessities to stay engaged in treatment and recovery activities.

Adding additional support funds to each Housing and Recovery through Peer Services (HARPS) contract to support case managers, outreach workers, Assertive Community Treatment Services for people experiencing homelessness, medications, coordination of other healthcare services and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Participant Support Funds will help the Housing and Recovery through Peer Support (HARPS) Teams to interweave care coordination, case management, and outreach services. People experiencing homelessness and behavioral health conditions benefit from connections to peer services and resources.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: MHAR-RSS2

Project Title: Participant Support Funds – Projects for Assistance in Transition from Homelessness (PATH) Teams

Proposed Budget: \$140,000

Scope:

Proposed support service funds will be added to the current contracted programs, Projects for Assistance in Transition from Homelessness (PATH). PATH programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency will be required to develop a detailed plan describing method and intended outcome for allocating client support service funding and submit to the Health Care Authority for approval by 09/30/2021. Plan must be based on Mental Health Block Grant (MHBG) guidance for Target Population* and Statement of Work.

Persistent and consistent outreach and providing services at the individual's pace are important steps to engage people with serious mental illness who are homeless. The proposed support service funds will enhance the quality of program delivery and engagement and expand critical client resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

Homeless outreach services intention is to reach individuals who are not currently engaged in services and potentially unable to navigate the system. The ability to have support services that offer basic needs upon engagement increases the likelihood for engagement in treatment and recovery.

PATH teams serve individuals experiencing homelessness and Serious Mental Illness (SMI) to BIPOC communities. BIPOC communities are overrepresented in homelessness. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: BGCE-RSS3

Project Title: Participant Support Funds – Peer Bridger

Proposed Budget: \$100,000

Scope:

The goal of this project is to use participant funds to connect people to community supports and treatment and reduce recidivism to the state hospital admissions. Keeping individuals engaged in peer services creates personal connection, accountability, and someone to assist in navigating complicated systems. Without these added supports the system continues to be a revolving door for many.

MHBG Funds could be used to support case managers, outreach workers, Assertive Community Treatment Services For people experiencing homelessness, medications, coordination with primary care, and case management.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support improves engagement and increases hope by modeling recovery. These complimentary services will enhance the already proven Peer Bridger model.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion (DEI) and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: MHAR-RSS12

Project Title: Adding a Peer to Projects for Assistance in Transition from Homelessness (PATH) Outreach Teams

Proposed Budget: \$1,759,433

Scope:

Proposed funds will continue funding for one peer counselor to the current Projects for Assistance in Transition from Homelessness (PATH). PATH programs assist individuals in accessing housing, mental health services, substance abuse treatment, disability benefits, and other services to stabilize them and facilitate recovery. Each agency hired a peer counselor to expand outreach and engagement services for individuals with a serious mental illness (SMI) and homeless or at risk of homelessness utilizing the Block Grant Covid Supplemental funding, this will continue support for those positions through mid-2025. Projects will work closely with BHASO's, MCO's and Crisis stabilization centers to create a referral flow and coordination of services.

This continued support for a PATH peer counselor on the PATH teams will allow agencies to expand needed outreach and engagement efforts. The proposed funds will enhance the quality of program delivery and engagement and expand critical crisis resources.

Addressing State Needs and Gaps, Including Gaps in Equity:

The intention of Homeless outreach services is to reach individuals who are not currently engaged in treatment, services and who are potentially unable to navigate the system. The ability to have one additional peer outreach team member will allow these programs to broaden the current outreach and engage services to a primary focus of crises response.

Projects for Assistance in Transition from Homelessness (PATH) teams currently serve individuals experiencing homelessness and mental illness and BIPOC communities. According to Research and Data Analysis (RDA) research, people who are homeless are more likely to be African American or Native American. (Ford-Shah, M., 2012)

Project #: MHAR-RSS14

Project Title: Operating Costs for a Housing Inventory/Estimator/Calculator **Proposed Budget:** \$10,000

Scope:

The Research and Data Analysis Division (RDA) within the Department of Social and Health Services (DSHS) completed a series of reports in 2012 examining the housing status of individuals following their exit from institutional or out-of-home care settings. More than one-quarter of all five study populations (individuals leaving Substance Use Treatment Facilities; State Department of Corrections Facilities; Foster Care; State Mental Hospitals and Juvenile Rehabilitation Facilities) experienced homelessness at some point over a 12-month follow-up period. This funding supports the online searchable tool based on various scenarios to connect individuals with behavioral health conditions to housing.

This searchable tool that will be housed on the Research and Data Analysis Pathways to Housing site will be used to help address the fact that almost 50 percent of Individuals leaving residential substance use treatment facilities became homeless within the year of discharge. Individuals exiting prison, foster care, State Mental Hospitals, and Juvenile Rehabilitation facilities were more likely to experience

homelessness but as likely to obtain to permanent housing when they received housing assistance. Across the five study populations, the proportion of individuals in need of housing who received Homeless Management Information System (HIMS)-recorded assistance was highest for youth aging out of foster care (at 35 percent). Even though this report is dated, it is believed these relate to the population we intend to start with: individuals with behavioral health issues still exist and may even be more exacerbated with the COVID pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will provide timely information for individuals with behavioral health conditions to access housing services and resources.

The searchable housing tool will ensure individuals with Behavioral Health conditions and part of the BIPOC population will have access to housing services and resources.

Project #: MHAR-RSS16

Project Title: Supportive Housing Institute

Proposed Budget: \$150,000

Scope:

DBHR proposes to use the proprietary curriculum from the Corporation for Supportive Housing to increase the number of affordable housing development for individuals with serious mental illness or serious emotional disturbance. HCA-DBHR will contract with CSH to assist with the design and implementation of two Supportive Housing Institutes (the "Institute") for the State of Washington whose completion will coincide with the capital and operating fund cycles of both 2022 and 2023. Each Institute will take place over a five-month period and allow for up to eight project teams per Institute. Each team will be required to include a SUD/MH service provider, developer, and operator (property manager) of a specific, proposed project. CSH will lead the teams through hands-on learning to take their projects from concept to fully developed project plans. Each Institute will produce projects that are well prepared for state and local funding and that align with the national Dimensions of Quality Supportive Housing, which include and supersede the fidelity indexes of SAMHSA, Pathways, and Watson HRM.

The HCA oversees the State's Medicaid benefits called Foundational Community Supports, which include supportive housing and supported employment services. Providers State-wide are expanding their delivery of these services to beneficiaries who are experiencing chronic homelessness, unnecessary institutionalization, and cycles of homelessness and system involvement, but scaling supportive housing itself remains constrained by a lack of supportive housing apartments. The HCA aims to build the capacity of mental health and substance use treatment providers to develop, operate, and/or form strong partnerships with other organizations to deliver new, high-quality supportive housing developments.

Addressing State Needs and Gaps, Including Gaps in Equity:

WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. Increases in homelessness also

increases experiences of trauma, co-occurring disorders, and increases chance of criminal justice interactions. The research is clear—homelessness, and unstable housing contribute to poor health. Homelessness is traumatic and cyclical; it puts people at risk for physical and mental health conditions and substance use disorders.

Foundational Community Supports utilizes the evidence-based practices of SAMSHA's Permanent Supportive Housing and Westat's individual placement and support. The principles of these evidence-based practices encompass the idea of a holistic, person centered approach, which is all inclusive and embraces zero exclusion, access to an individual's choice of services. These services also value and approach participants with equity, respect as well as cultural humility with the hope of promising outcomes.

Project #: BGCE-RSS19

Project Title: Cover Foundational Community Support (FCS) Services in Institution of Mental Disease (IMD) When Medicaid is Suspended

Proposed Budget: \$500,000

Scope:

The Division of Behavioral Health and Recovery proposes to utilize block grant funds to cover Foundational Community Support services for people transitioning out of Institution of Mental Disease (IMD) settings if the Medicaid isn't retroactively reconnected. The Foundational Community Support (FCS) program assists eligible individuals with complex health needs obtain and maintain stable housing and can provide Foundational Community Support services within short-term Institution of Mental Disease (IMD) settings with housing assessments and begin the housing acquisition process prior to discharge. These newly added services to Foundational Community Support will include coaching, advocacy, information and referral, linking and coordinating, and ongoing supports that they may not otherwise have access to.

The program offers an array of transition/pre-tenancy and tenancy-sustaining supports that have been effective in improving housing stability, health and employment outcomes for high need Medicaid beneficiaries. linking and coordinating, and ongoing supports that they may not otherwise have access to. Many of these individuals have complex health profiles and face multiple housing related barriers to effectively engaging with health care systems and managing their own plan of care to achieve improved health and wellness. Foundational Community Support have reduced the frequent use of emergency department and inpatient care, addressed significant gaps in connections to care, addressed homelessness, and now can help to facilitate timely, successful transitions from institutional settings to integration in community placements. Anticipated Outcomes:

- Effectively target interventions to eligible individuals in residential treatment settings;
- Streamline and standardize transition and tenancy-sustaining services for individuals exiting residential treatment across agencies and systems;
- optimize and braid all available funding to fill gaps;

- reduce Substance Use Disorder/Opioid Use Disorder (SUD/OD) related deaths;
- improve Substance Use Disorder system capacity; and
- improve quality of care

Addressing State Needs and Gaps, Including Gaps in Equity:

Currently there is no other mechanism to reimburse Foundational Community Support providers if the individuals Medicaid is not active at the time of authorization. The Health Care Authority has taken steps to attempt to mitigate this by providing Foundational Community Support providers access to Provider One to check Medicaid eligibility. This however is not a perfect solution and there are times when Foundational Community Support providers go unpaid.

The Foundational Community Support program is based on the evidence-based practices (EBP) of Permanent Supportive Housing (PSH) and Individual Placement and Support (IPS). The principles of these Evidence-Based Practices encompass equity and racial justice through the promotion of choice, flexible voluntary services, and access.

Project #: BGCE-RSS24

Project Title: Peer Pathfinders Transition from Incarceration Pilot

Proposed Budget: \$790,000

Scope:

This funding will continue support for a Certified Peer Counselor to up to five existing BH-ASO contracts for jail transition services. Adding a Certified Peer Counselor to existing jail transition services teams will increase the level of services being provided, by having a CPC connect with the individuals while they are still in jail and helping them with transition to the community. The certified peer counselor will work with individuals diagnosed with a serious mental illness, linking them to behavioral health services, including co-occurring treatment, Foundational Community Support (FCS), and other applicable services.

Multiple studies support the fact that Peer support services has significant impacts on quality of life, reducing substance use, and improving positive social supports. Studies have also identified common elements of peer support, suggesting possible processes that underlie effective peer support. Peer services include shared experiences, role modelling, and positive social support. All of which are suggested to be vital aspect of peer support and moderate positive life changes. By adding a certified peer counselor to existing Jail Transition services allows for access to these vital services for individuals with SMI and co-occurring health conditions, reducing likelihood for further court involvement. Impacts that are likely to occur if this project is not approved included recidivism because the individual was not provided the needed services during their jail transition.

Addressing State Needs and Gaps, Including Gaps in Equity:

People exiting jails are more likely to be successful when they are able to connect and engage in services in their communities upon release. Currently in some parts of the state jail transition services are only reaching jail populations a few times a month. By adding a Certified Peer Counselor to existing jail transition services, individuals who are in need of extra support in accessing community-based services can be offered the support of a peer. These certified peer counselors would focus on linking individuals

to behavioral health services, including co-occurring treatment, housing and employment, and community resources.

A disproportionate number of individuals of color are represented in our criminal court system and they experience greater barriers in accessing healthcare and community behavioral healthcare. This problem is greater amplified the further away you move from urban settings and locations in which more services are available. By adding the support of a Certified Peer Counselor to existing jail transition services, this will increase the likelihood of individuals being able to overcome some of these barriers.

Project #: BGCE-RSS25

Project Title: Add Co-Occurring Peer to F-HARPS

Proposed Budget: \$400,000

Scope:

These additional funds would continue support for a certified peer counselor for each Forensic HARPS team in the phase 1 regions, originally funded through the Block Grant Covid Supplemental award. With this additional staff person, the teams would be able to increase caseload capacity. This position would also allow the Forensic HARPS teams to serve individuals diagnosed with serious mental illness or co-occurring.

This project is critical because it will increase the capacity of the teams to serve more eligible individuals through the Forensic HARPS program, an element of the Trueblood Settlement. Housing access, support, and short-term subsidies increase an individual's opportunity for recovery. Housing is a basic need that reduces the likelihood of recidivism in the criminal court system. If this funding is not approved, the Forensic HARPS teams will not be able to serve all those who are eligible and in need of this service.

Addressing State Needs and Gaps, Including Gaps in Equity:

The Forensic HARPS teams have short-term housing subsidy dollars to assist participants in obtaining and maintaining housing. The amount of subsidy dollars allocated to each team is greater than what the current staffing model allows them to spend. With this additional staff person, the Forensic HARPS teams will be able to fully utilize the subsidy dollars allocated to them. Funding Forensic HARPS teams is cost effective because it diverts individuals with serious behavioral health conditions into receiving the services, they need instead of being arrested or hospitalized. Supportive housing reduces inpatient hospitalization, incarceration and engagement in outpatient treatment increases when individuals are successfully housed (RDA, FCS preliminary outcomes 2020).

Helping individuals obtain and maintain housing of their choice helps them be more successful in treatment. Forensic HARPS teams are trained in leveraging all community resources once an individual exits jail or an institutional setting, but the 'bridge subsidy' is still needed in order to assist individuals exit jail as quickly as possible.

A disproportionate number of individuals of color are represented in our criminal court system. Many of these individuals experience significant barriers in accessing safe and affordable housing. WA State has a serious deficit of safe and affordable housing, and in turn, people are unable to maintain and/or obtain housing, increasing the number of unhoused individuals. People with trauma, a history of

homelessness, and co-occurring disorders have an increased likelihood of being involved in the criminal court system. Helping individuals find and maintain housing of their choice, and obtain wanted services, especially during an increased time of hardship such as COVID-19 is our states responsibility.

Project #: BGCE-RSS36

Project Title: Funding for SSI/SSDI, Outreach, Access, and Recovery (SOAR) Leads

Proposed Budget: \$500,000

Scope:

SSI/SSDI Outreach Access and Recovery (SOAR) is a proven effective model to increase access to governmental benefits. This project would create a SOAR Lead Position in multiple regions/counties (scalable). SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads hold local steering committee meetings, lead SSI/SSDI, Outreach, Access and Recovery (SOAR) online course training cohorts and conduct half-day SSI/SSDI, Outreach, Access and Recovery (SOAR) online course review sessions. SSI/SSDI, Outreach, Access and Recovery (SOAR) Leads will also be mentoring individuals who complete the SSI/SSDI, Outreach, Access and Recovery (SOAR) online course and reporting on outcomes.

This will provide increased access to the disability income benefit programs administered by the Social Security Administration (SSA) for eligible adults who are experiencing or at risk of homelessness and have a serious mental illness. Access to these benefits will help individuals stabilize their housing and health.

Addressing State Needs and Gaps, Including Gaps in Equity:

Many unhoused individuals qualify for disability benefits but have a difficult time getting through the application process. With an SSI/SSDI, Outreach, Access Recovery (SOAR) Representative assisting with the application process, individuals are approved more often and more quickly. Most landlords require some kind of monthly income, this will help provide that and allow more individuals to obtain housing.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote Diversity, Equity and Inclusion and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Project #: BGCE-RSS41

Project Title: Enhance Mobile Crisis Teams with CPCs

Proposed Budget: \$1,909,000

Scope:

HCA will build upon the Transformation Transfer Initiative (TTI) crisis services continuing education curriculum for Certified Peer Counselors by piloting enhancements to mobile crisis teams by adding Certified Peer Counselors to existing teams. Funds will be issued to BH-ASOs to expand Mobile Crisis Response services serving those diagnosed with SMI/SED.

This project will provide enhance mobile crisis services by continuing support for certified peer counselors in Washington State. The intended outcome is to increase the engagement and outreach of MCR teams to include certified peer counselors to even more effectively support the peers they serve in crisis settings.

Addressing State Needs and Gaps, Including Gaps in Equity:

Research shows peer support services improves engagement in increases hope by modeling recovery. Peer supports have also been shown to increase community tenure and reduce substance use disorder relapse. Expanding mobile crisis services to include Certified Peer Counselors will better support people as Washington expands peer services in crisis settings.

All programs will ensure services and activities will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations typically underserved and marginalized in the system. Culturally and Linguistically Appropriate Services (CLAS) standards are required for all programming. Programs will promote DEI and provide specific outreach to the BIPOC communities, and employ staff that reflect the individuals we serve, ensuring health equity through policy, practices and resources. When providing training, contractors will reach out to community to ensure culture is appropriate and respected.

Tribal Projects Detail

Project #: MHAR-TRB1

Project Title: TARGET (database) Replacement

Proposed Budget: \$200,000

Scope:

Based on a pilot to work with a Tribe that currently has EPIC to develop a mechanism to automatically upload SAMHSA-required data to HCA's behavioral health data store, with minimal double entry of data, this project will support the expansion and maintenance of this pilot to other Tribes across the state. This project will offer funding to maintain the behavioral health data system that will replace the previously used TARGET system.

This project will ensure that there is maintenance for the data system that will support the collection of SAMHSA-required data. As the pilot will help HCA to identify if we can use an existing EHR to build the necessary system to meet the needs of the Tribes and the state in SUD and mental health data

collection for our reporting to our federal partners/funders and the state legislature, this project will maintain these efforts and address any system improvements needed along with the evolving landscape for behavioral health data collection and reporting.

Addressing State Needs and Gaps, Including Gaps in Equity:

Tribes requested a solution for the TARGET replacement in 2016. Providing funding resources to maintain and improve data collection for Tribes will address a long-time gap for Tribal communities in SUD and mental health data collection in the new integrated health care environment.

This project will systemically improve data reporting and surveillance of AI/AN communities to better address any health disparities. Data is very important in identifying needs and strengths in BIPOC communities.

Project #: MHAR-TRB3

Project Title: Funding to Tribes and Urban Indian Health Organizations **Proposed Budget:** \$1,460,114

Scope:

The Health Care Authority will provide contracts to 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver needed behavioral health, mental health services for individuals with SMI/SED and substance use disorder prevention, treatment, OUD intervention and recovery supports services within their Tribal communities. Tribes will submit a plan to implement recommended services as outlined in the NOA and allowed within the SABG/MHBG regulations. Additional funds for Tribes will be divided evenly between the Tribes and Urban Indian Health Programs (UIHP) (Native Project & SIHB). These funds will begin on March 2023 - Sept 2025 and may be an extension of the Tribe's and UIHP's COVID Enhancement projects to ensure a full recovery from the impacts of the COVID pandemic.

This project is important because AI/AN and Tribal communities have been greatly affected by the COVID pandemic and the various Tribal and State Stay at Home Orders. Tribes are identifying ways to maintain some of their BH program in a virtual and semi/virtual environment. Due to the pandemic, Tribes are stating that the individuals in their communities are struggling with social isolation and a lack of treatment services due to the pandemic. There has also been limited cultural activities available for Tribal communities due to the pandemic. The historic annual Canoe Journey was canceled two years in a row with very limited ability to implement cultural programs across all Tribal communities. These funds will support the Tribe's and UIHP's ability to address any gaps and needs in their behavioral health services and increase support individuals that may have lingering behavioral health impacts due to the COVID 19 pandemic.

Addressing State Needs and Gaps, Including Gaps in Equity:

Department of Health (DOH) reported that overdose rates have gone up over 154% during the first 6 months of the pandemic and is the highest of other communities by race/ethnicity. The statewide increase overall is 30%. The Health Care Authority needs to continue to provide resources to Tribal communities to address those diagnosed with SMI or SED for American Indian/Alaskan Native (AI/AN) in WA. Providing direct funding to Tribes and Urban Indian Health Programs (UIHPs) also honors our

government-to-government relationships by partnering with Tribes to serve American Indian/Alaskan Native WA State residents.

This project directly supports Diversity, Equity and Inclusion (DEI) by providing needed services to the American Indian/Alaskan Native (AI/AN) population in providing culturally appropriate services. This also honors our unique Government-to-Government (G2G) relationships with Tribal governments and our partnership with Urban Indian Health Programs (UIHPs).

Crisis Services:

Tribes and Urban Indian Health Programs (UIHPs) may provide crisis services with these funds. The Health Care Authority will pass down National Guidelines to Tribes to provide guidance on best practices for crisis services.

Crisis Set-Aside Projects Detail

Project #: MHAR-ASO2

Project Title: Behavioral Health Administrative Service Organization (BH-ASO) Treatment Funding for Crisis Services

Proposed Budget: \$3,320,228

Scope:

Funding directed to the Behavioral Health Administrative Service Organizations (BH-ASO's) will support their respective crisis provider networks enhancing the provision of comprehensive community mental health services to individuals who are either adults with a serious mental illness (SMI) or children with serious emotional disturbances (SED) as defined by the Psychiatric Association's Diagnostic and Statistical Manual (DSM) of Mental Disorders. Funding will be used to enhance existing Crisis Services provided 24 hours a day, seven days a week including crisis call line, evaluation and treatment services for Individual's ineligible for Medicaid, including involuntary inpatient services, voluntary inpatient services, crisis stabilization services, Employment and Training (E&T) services, and services for the priority populations defined per Contract. Services also include 24-hour-a-day emergency care services, mobile crisis, crisis line, and Designated Crisis Responder (DCR) services.

This funding is critical for enhancing and improving statewide behavioral health system and community-based service capacity for adult individuals diagnosed as Serious Mental Illness (SMI) and youth diagnosed with Serious Emotional Disturbance (SED). This funding is also critical to improve the mental health crisis system of care. This funding will enable workforce enhancement and stabilize staff shortages and retainment issues that have increased throughout the behavioral health delivery system during the pandemic. All funded crisis workers will be required to be trained in trauma informed care, de-escalation techniques and the fundamentals of harm reduction.

Addressing State Needs and Gaps, Including Gaps in Equity:

This project will address the needs related to statewide enhancement of timely access to community-based outpatient, crisis, recovery support and outreach mental health services. This also addresses ongoing issues of behavioral health staff recruitment and retention. This funding will address gaps in access to timely community-based services including outpatient treatment for uninsured individuals, services for individuals experiencing co-occurring disorders, transportation support, transition support services including recovery support housing, individuals transitioning from inpatient psychiatric care, homeless outreach, support for individuals transitioning from jails, services to meet needs of veterans and service members, people experiencing poverty, people of color and barriers experienced by non-English speaking individuals.

This project will support a statewide community based mental health engagement and service delivery system that acknowledges individual and institutional bias have excluded marginalized members of our communities. This funding enhances a system that works toward equity and inclusion recognizing that policies and procedures have had different negative effects on marginalized communities. This also supports an understanding that black indigenous people of color have distinctly unique needs and expectations and that engagement and treatment services are strategically implemented and culturally relevant.

This project supports the implementation of quality integrated health care to all persons without regard to race, color, national origin, gender, disability, religion, creed, age or sexual orientation. Organizations funded by this project will engage in ongoing efforts to improve services and ensure the implementation of the National Standards for Culturally and Linguistically Appropriate Services.

Crisis Services:

This project will enhance statewide community based mental health crisis services consistent with the National Guidelines for Behavioral Health Crisis Care that includes an effective strategy for suicide prevention, approaches that better align care to the unique needs of the individual, preferred strategies for individuals in distress that offers services focused on resolving mental health and substance use crises, strategies to reduce psychiatric hospital bed overuse and eliminate psychiatric boarding in emergency departments; and strategies to reduce the fragmentation of mental health care.

Technology Infrastructure Projects Detail

Project #: MHAR-TEC1

Project Title: Clinical Data Repository

Proposed Budget: \$325,000

Scope:

This funding request is to support technological enhancements to the CDR that will allow retention of historical clinical data, including MH/SUD data, as well as implementation of an analytic enclave environment. This solution will allow authorized users, including researchers, evaluators, state staff, clinicians and others to access protected health information in a secure environment in order for them

to conduct their research and analyses, without the need for these data to leave the CDR secure environment. This will support programmatic enhancements, overall program governance, and analytics in order to achieve meaningful results and support other key efforts such as Value Based Purchasing, Health Care Transformation and Health Care Cost/Quality Transparency.

The current Medicaid CDR was established several years ago. There is now a need to enhance the current CDR and define a strategic vision focused on clinical quality and outcome analytics, total cost of care analytics and care coordination functions especially focused on MH/SUD clients. Washington's CDR presents a unique opportunity to develop a true clinical data warehouse that is leveraged in conjunction with other State data assets such as the All-Payer Claims Database (APCD), the Health Information Exchange (HIE), Public Health disease registries and others, to generate true total cost of care and care quality/outcome analytics to inform research, policy and health system transformation.

Addressing State Needs and Gaps, Including Gaps in Equity:

Care coordination for MH/SUD clients is greatly impeded currently by a lack of seamless data exchange between providers. The CDR is a critical data asset which has the capabilities to help bridge this gap. This investment will significantly enhance the technological ability of this tool to enable appropriate and secure data sharing amongst those who need it in order to better serve the MH/SUD clients in Washington.

Medicaid clients who need MH/SUD services are amongst the most vulnerable populations in our care. As stated above, care coordination for MH/SUD clients is greatly impeded currently by a lack of seamless data exchange between providers. The CDR is a critical data asset which has the capabilities to help bridge this gap and help enhance equitable access to information about clients to their providers. This investment will significantly enhance the technological ability of this tool to enable appropriate and secure data sharing amongst those who need it in order to better serve the MH/SUD clients in Washington.

Health IT Infrastructure

The Clinical Data Repository as implemented in the state of Washington is compliant with health information technology standards and implementation specifications as identified in 45 CFR 170, Subpart B.

Project #: MHAR-TEC2

Project Title: Consent Management Solution

Proposed Budget: \$1,300,000

Scope:

The electronic consent management solution, which has been approved by Washington State HHS agencies, will be a key foundational investment in the state's health information exchange infrastructure and will enable meaningful, seamless exchange of protected and sensitive BH and PH information amongst those who are authorized to receive it in order to deliver services to Washingtonians.

Every initiative to support Behavioral Health Integration requires Behavioral Health (BH) and Physical Health (PH) data to be seamlessly shared amongst clinicians, and across the care continuum. Care coordination, case management, population health and even public health, as evidenced during this past

year, are highly dependent on this seamless exchange of information. In addition to direct care clinicians, others in the care system such as care coordinators, case managers, managed care organizations, public health entities and others also need access to such data in order to be able to fulfill their respective missions. Lack of a standardized, centralized consent management solution has presented a significant barrier to realizing true BH-PH integration.

Addressing State Needs and Gaps, Including Gaps in Equity:

Care coordination for MH/SUD clients is greatly impeded currently by a lack of seamless data exchange between providers. A centralized consent management solution is a critical investment which will provide the capabilities to help bridge this gap. This investment will significantly enhance the technological ability that enables appropriate and secure data sharing amongst those who need it in order to better serve the MH/SUD clients in Washington.

Medicaid clients who need MH/SUD services are amongst the most vulnerable populations in our care. As stated above, care coordination for MH/SUD clients is greatly impeded currently by a lack of seamless data exchange between providers. A centralized consent management solution is a critical investment which will provide the capabilities to help bridge this gap and help enhance equitable access to information about clients to their providers. This investment will significantly enhance the technological ability to enable appropriate and secure data sharing amongst those who need it in order to better serve the MH/SUD clients in Washington.

Health IT Infrastructure

The consent management solution will meet health information technology standards and implementation specifications as identified in 45 CFR 170, Subpart B. Specifically, the consent management solution will be interoperable with ONC certified Electronic Health Record (EHR) systems and will use HL7 FHIR standards for secure data exchange between systems.

Project #: SAAR-TEC3

Project Title: Statewide Bed Registry

Proposed Budget: \$1,414,478

Scope:

This project will develop and implement a statewide bed registry to track capacity and real-time bed availability for psychiatric hospital beds, freestanding evaluation and treatment center beds, Secure Withdrawal Management and Stabilization Beds, crisis triage/stabilization beds, and substance use disorder residential treatment beds. The registry is intended to include both adult and youth/child beds.

Contracted resources will be utilized to implement this new solution, with management of maintenance and operations to be supported by existing staff resources.

The lack of a statewide bed registry has been a long-standing problem within the state. The need has been discussed in multiple work groups. This would include the legislative BHRST group and the ITA Work Group required by SB 5720. Both these workgroups have included stakeholder and consumer testimony on how difficult it is for a crisis worker, an individual or family member to find an available treatment bed. Currently, without a bed registry, multiple facilities have to be called to see if they provide the appropriate treatment services and to see if they have any vacant beds. Sometimes this process involves calling up to 20 facilities. Implementation of a registry will make it significantly easier to

locate beds and access care. If this is not approved, crisis workers, individuals and families will continue to face obstacles in accessing critical care.

Addressing State Needs and Gaps, Including Gaps in Equity:

Ready access to mental health and substance use disorder treatment beds will benefit all populations. We know that due to social determinants of health and historical trauma, there is a disproportionate need for care for BIPOC individuals. That care should be readily available.

Health IT Infrastructure

The Statewide Bed Registry in the state of Washington will be compliant with health information technology standards and implementation specifications as identified in 45 CFR 170, Subpart B.

Washington

COVID-19 Testing and Mitigation Work Plan for FY22-25

Revised February 2024

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

Center for Mental Health Services
Division of State and Community Systems Development

Mental Health Block Grant COVID-19 Testing and Mitigation Work Plan

WA State Summary

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COVID-19 has both increased and revealed the need for a wide range of mental health services. Washington state is expanding mental health services across the continuum of care, from out-patient counseling services to recovery support services like housing and employment after treatment stays.

A crucial part of service expansion is building new residential facilities for civilly committed 90- and 180-day stays, a growing need in communities across the state. The hope is that if people need more intensive treatment, there is treatment available in or near their community. While many are supportive of mental health treatment generally, residential facilities can be misunderstood by community members. The sentiment from community members resistant to localized services has been, "we support mental health services but...not in our backyard."

Stigma is one of the largest barriers to expanding mental health infrastructure. It is also one that can be addressed proactively through public education, addressing misconceptions and connecting with allies across sectors.

The Washington Health Care Authority respectfully submits the proposal and budget summary you will find below. Our original intention for this funding was to purchase and distribute Covid-19 rapid tests to behavioral health providers, which was a critical need at the time we submitted our proposal. However, our providers no longer have that urgent need, so we are requesting to shift this funding into addressing mental health stigmas, some of which resulted from or were compounded by the Covid-19 pandemic.

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Total Budget	\$	1,142,613

Covid Mitigation Project Detail

Project #: MHCM-01

Project Title: Mental Health Stigma Campaign

Proposed Budget: \$1,085,482

Scope:

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Our strategy to address stigma focuses on three areas:

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- Proactively engaging communities around proposed sites

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- Women 55+ diagnosed with SMI
- Middle to upper income brackets
- Active in community efforts

We are setting aside a total of 5% for administrative costs associated with the management of this project. Any unused administrative costs will go towards the stigma campaign.

Washington

COVID-19 Testing and Mitigation Work Plan for FY22-25

Revised February 2024

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

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Division of State and Community Systems Development

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Project #: MHCM-01

Project Title: Mental Health Stigma Campaign

Proposed Budget: \$1,085,482

Scope:

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SAMHSA
Office of Financial Resources, Division of Grants Management
Center for Substance Abuse Treatment, Division of State and Community Systems
Center for Substance Abuse Prevention, Division of Primary Prevention
Center for Mental Health Services, Division of State and Community Systems Development

Request for second No Cost Extension (NCE) for SUPTRS and MHBG COVID-19 Supplemental Funding

Declaration of Intent: Required by Wednesday, March 13, 2024, 11:59 PM, ET

Request for second NCE: Required by Friday, March 22, 2024, 11:59 PM ET

COVID-19 Award Issue Date: 3/11/21 **Current Approved Expenditure Period:** 3/15/21 - 3/14/24

SAMHSA has heard from recipients of the MHBG and SUPTRS BG (referred to as the SABG when the funding was initially awarded) that they would benefit from additional time to complete programmatic activities approved as part of their FY 21 Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA) COVID-19 Supplemental Funding award. Accordingly, SAMHSA is expanding the flexibility in the notice sent to all states with active CRRSA block grant awards on February 14, 2024.

Current MHBG and SUPTRS grantees with active CRRSA block grant awards may request a second NCE under the FY 21 COVID-19 Supplemental Funding award for an additional expenditure period of up to twelve (12) months, through March 14, 2025. The second NCE cannot be used to initiate new projects or activities and must be implemented in accordance with:

- the grantee's SAMHSA currently approved MHBG COVID-19 Supplemental Funding Plan, or SUPTRS COVID-19 Supplemental Funding Plan, as previously communicated to the grantee by the CMHS or CSAT State Project Officer;
- the March 11, 2021, Notice of Award (NoA) Terms and Conditions for the MHBG COVID-19 Supplemental Funding or the SABG COVID-19 Supplemental Funding; and
- the March 11, 2021, COVID-19 Supplemental Funding Guidance Letter to the SSA Directors and the SMHCs from Tom Coderre, then Acting Assistant Secretary for Mental Health and Substance Use.

No further action is required by grantees who have already been approved for additional time to phase out and reconcile their FY 21 CRRSA block grant award and do not require additional time to complete programmatic activities. However, if interested, these recipients may also request a second NCE described below. Following the end of the second NCE grantees will still be afforded the 90-day closeout period.

Instructions for submitting a Declaration of Intent and Request for a second NCE:

Declaration of Intent:

Grantees who would like to request a second NCE must notify SAMHSA in writing **no later than Wednesday, March 13, 2024, at 11:59 PM ET** of their intent to take advantage of this flexibility. The declaration of intent must state that the grantee will submit a full NCE for COVID-19 Supplemental Funding by the stated deadline of Friday, March 22, 2024. This declaration of intent serves as preliminary approval of the NCE and will allow grantees who receive final approval of their NCEs the **ability to charge costs to the grant dating back to March 15, 2024**. Grantees may submit a single email containing separate Declarations of Intent for the SUPTRS NCE and the MHBG NCE. Requests should be emailed to:

- **Wendy Pang at wendy.pang@samhsa.hhs.gov, and**
- **Your assigned CMHS or CSAT State Project Officer**

Upon receipt of the Declaration of Intent, the CMHS and/or CSAT State Project Officer will create and send the grantee a Revision Request in the FY 21 MHBG Plan and/or FY 21 SABG Plan in WebBGAS, with instructions for uploading the NCE Request (see below) as an Attachment in the FY 21 MHBG Plan and/or the FY 21 SABG Plan. Further information about this process may be requested from your CMHS, CSAT, or CSAP State Project Officer (SPO).

CSAT-DSCS-SSPB Word Version of 2nd NCE Request for FY 21 SUPTRS (SABG) COVID-19 Supplemental Funding

Request for second No Cost Extension (NCE):

For both the SUPTRS and MHBG, the SPO will initiate a Revision Request in WebBGAS in the FY 21 SUPTRS and/or FY 21 MHBG Plan, under Section I, as an addendum to the *CEO's Funding Agreement*, with the grantee requested to upload the Attachment to the FY 21 SUPTRS and/or MHBG Plan.

Grantees must submit the information below (as a Word document or PDF file) to WebBGAS no later than **Friday, March 22, 2024, at 11:59 PM ET.**

Check One: ☒ Request for Second NCE for FY 21 **MHBG** COVID-19 Supplemental Funding
☐ Request for Second NCE for FY 21 **SUPTRS** COVID-19 Supplemental Funding

A. Name of MHBG or SUPTRS Grantee Organization	Washington State Health Care Authority		
B. Date of Submission of NCE Request	3/13/24	C. Length of Time Requested (in Months) for NCE (12 Mo. Max. through 3/14/25)	12 months

D. Name and Title of Grantee Finance Official Approving This NCE Request	[REDACTED], Behavioral Health Grants Supervisor		
E. Name and Title of Grantee Program Official Approving This NCE Request	[REDACTED], Federal Block Grant Administrator		
F. Name and Title of Other Grantee Official Approving This NCE Request	[REDACTED], Acting Director, Division of Behavioral Health and Recovery		
G. COVID-19 Award Total \$ Amount Issued in NoA of 3/11/2021	\$19,222,372	H. COVID-19 Award Total \$ Amount Expended as of NCE Request Date Above	\$14,141,999
I. COVID-19 Award Total \$ Amount Planned to be Expended through 3/14/2025	\$5,080,373	J. COVID-19 Award Total \$ Amount Requested for NCE	\$5,080,373
K. Please provide a brief justification of the need for the NCE to complete current programmatic activities approved as part of your FY 21 Coronavirus Response and Relief Supplemental Appropriations Act (CRRSA) COVID-19 Supplemental Funding award.			
As with other states, Washington state has suffered from a multitude of challenges, which include but are not limited to workforce shortages that have impacted all levels of our behavioral health system. We have been able to spend the majority of these funds within the time allotted, but these workforce impacts have caused delays. Washington appreciates the opportunity for a No-Cost Extension on the Covid Enhancement awards received for the Mental Health Block Grant as these funds are essential in providing critical services to Washington State's most vulnerable populations.			

The Health Care Authority is working closely with contractors and providers to ensure all MHBG Covid-19 Enhancement funds are fully utilized. Steps being taken include reviewing all projects and contracts with contract managers, reaching out to our contractors to review timelines and deliverables, identifying what can be completed by March 14th, 2024 and what would benefit from an extension to ensure completion. Monthly check-ins with contract managers will continue to allow us to manage these funds efficiently and address any issues that may arise. This no cost extension will allow the greatest maximization of funding to serve these vulnerable populations in Washington.

Washington

COVID-19 Testing and Mitigation Work Plan for FY22-25

Revised February 2024

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

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Exhibit G

From: [REDACTED]@samhsa.hhs.gov
To: [REDACTED]
Cc: [REDACTED]
Subject: B09SM085384: Termination Notice for COVID-19 Grant Funding
Date: Monday, March 24, 2025 2:50:02 PM

External Email

Dear Single State Authority Director and State Mental Health Commissioner,

During the COVID-19 pandemic, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded several pandemic-related grants including the funded [Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020](#) (H.R.6074) (CRRSA) which provided funds to respond to the coronavirus outbreak and the [American Rescue Plan](#) (ARP) Act of 2021(H.R. 1319) which provided additional relief to address the continued impact of COVID-19 (i.e., coronavirus disease 2019) on the economy, public health, state and local governments, individuals, and businesses.

On April 10, 2023, President Biden signed [PL 188-3](#) terminating the national emergency concerning the COVID-19 pandemic. Consistent with the President's Executive Order 14222, Implementing the President's "Department of Government Efficiency" Cost Efficiency Initiative requiring a comprehensive review of SAMHSA grants, and where appropriate and consistent with applicable law, terminate such grants to reduce the overall Federal spending **this grant is being terminated effective March 24, 2025**. These grants were issued for a limited purpose: To ameliorate the effects of the pandemic. The end of the pandemic provides cause to terminate COVID-related grants. Now that the pandemic is over, the grants are no longer necessary.

In accordance with [45 CFR 96.30 \(4\)](#), block grant award recipients are required to provide a Financial Status Report (FFR) within 90 days of the close of the applicable statutory grant period. Recipients must liquidate all obligations incurred under an award after the end of the award obligation and expenditure period (i.e., the project period) which also coincides with the due date for submission of the FINAL SF-425, Federal Financial Report (FFR). Reimbursements after termination are allowable if it results from obligations which were properly incurred before the effective date of this termination.

Recipients are expected to complete all work immediately and the reconciliation/liquidation process no later than 90-days after the award period end date.

The related Payment Management System accounts will be restricted from drawdown going further. Additional information will be provided in the revised Notice of Award that will be issued to initiate the award period end date.

[[Correspondence Token: 85b836fd-4e65-4b1f-899e-efee1a6ee5a8]] -- Do not delete or change this line. --

Please "Reply All" and do NOT delete eracorrespondence@nih.gov from the list of recipients or change the subject line.

Exhibit H

From: [REDACTED] (SAMHSA/OFR)
To: [REDACTED]
Cc: [REDACTED]
Subject: B09SM085384: Block Grant Termination Notice for COVID-19 Awards (CRRSA and ARP)
Date: Friday, March 28, 2025 9:33:02 AM
Attachments: [95-8648 BG hearing procedure.pdf](#)

External Email

Dear Single State Authority Director and State Mental Health Commissioner,
You received notification on March 24, 2025, that your award was being terminated. This notice replaces and supersedes the previous notice.
During the COVID-19 pandemic, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded several pandemic-related grants funded by the [Coronavirus Response and Relief Supplemental Appropriations Act \(CRRSA\)](#) which provided funds to respond to the coronavirus outbreak and the [American Rescue Plan \(ARP\)](#) Act which provided additional relief to address the continued impact of COVID-19.
The termination of this award is for cause. The block grant provisions at [42 U.S.C. §300x-55](#) permit termination if the state “has materially failed to comply with the agreements or other conditions required for the receipt of a grant under the program involved.” The end of the pandemic provides cause to terminate COVID-related grants and cooperative agreements. These grants and cooperative agreements were issued for a limited purpose: to ameliorate the effects of the pandemic. Now that the pandemic is over, the grants and cooperative agreements are no longer necessary as their limited purpose has run out. Termination of this award is effective as of 11:59PM EDT, March 24, 2025.
In accordance with [45 CFR 96.30 \(4\)](#), block grant award recipients are required to provide a Financial Status Report (FFR) no later than 90 calendar days after March 24, 2025. Recipients must liquidate all obligations incurred under an award no later than 90 calendar days after March 24, 2025, which also coincides with the due date for submission of the FINAL SF-425, Federal Financial Report (FFR). Reimbursements after termination are allowable if the reimbursements result from obligations which were properly incurred on or before March 24, 2025.
Recipients are expected to cease all activities immediately and complete the reconciliation/liquidation process no later than 90 calendar days after the termination effective date.

Opportunity for Hearing:

Per the enclosed hearing procedures, block grant recipients may request a hearing to dispute this decision by submitting a written notice to the Substance Abuse and Mental Health Services Administration (SAMHSA) requesting a hearing within 15 calendar days of the date of this notice to: SAMHSAgrants@samhsa.hhs.gov. The request for a hearing must include a copy of this termination notice and a brief statement of why this decision should not be upheld.

Enclosure

[[Correspondence Token: 246e7ca1-dad6-4f5a-b39b-2e57fcd81908]] -- Do not delete or change this line. --

Please 'Reply All' and do NOT delete eracorrespondence@nih.gov from the list of recipients or change the subject line.

Exhibit I



Recipient Information

1. Recipient Name

HEALTH CARE AUTHORITY
626 8TH AVENUE SE

OLYMPIA, WA 98501

2. Congressional District of Recipient

10

3. Payment System Identifier (ID)

1911412780A1

4. Employer Identification Number (EIN)

911412780

5. Data Universal Numbering System (DUNS)

007207571

6. Recipient's Unique Entity Identifier

7. Project Director or Principal Investigator

[REDACTED]

[REDACTED]

8. Authorized Official

Federal Agency Information

9. Awarding Agency Contact Information

[REDACTED]

Grants Management Specialist
Center for Mental Health Services

[REDACTED]

[REDACTED]

10. Program Official Contact Information

[REDACTED]

Center for Mental Health Services

[REDACTED]

Federal Award Information

11. Award Number

1B09SM085912-01

12. Unique Federal Award Identification Number (FAIN)

B09SM085912

13. Statutory Authority

Subparts I&III,B,Title XIX,PHS Act/45 CFR Part96

14. Federal Award Project Title

Block Grants for Community Mental Health Services

15. Assistance Listing Number

93.958

16. Assistance Listing Program Title

Block Grants for Community Mental Health Services

17. Award Action Type

New Competing

18. Is the Award R&D?

No

Summary Federal Award Financial Information

19. Budget Period Start Date 09/01/2021 – End Date 09/30/2025

20. Total Amount of Federal Funds Obligated by this Action \$1,142,613

20 a. Direct Cost Amount \$1,142,613

20 b. Indirect Cost Amount \$0

21. Authorized Carryover

22. Offset

23. Total Amount of Federal Funds Obligated this budget period \$1,142,613

24. Total Approved Cost Sharing or Matching, where applicable \$0

25. Total Federal and Non-Federal Approved this Budget Period \$1,142,613

26. Project Period Start Date 09/01/2021 – End Date 09/30/2025

27. Total Amount of the Federal Award including Approved Cost \$1,142,613

Sharing or Matching this Project Period

28. Authorized Treatment of Program Income

Additional Costs

29. Grants Management Officer - Signature

[REDACTED]

30. Remarks

Acceptance of this award, including the "Terms and Conditions," is acknowledged by the recipient when funds are drawn down or otherwise requested from the grant payment system.

Notice of Award



MHBG
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

Issue Date: 08/10/2021

Center for Mental Health Services

Award Number: 1B09SM085912-01

FAIN: B09SM085912-01

Contact Person: [REDACTED]

Program: Block Grants for Community Mental Health Services

HEALTH CARE AUTHORITY
626 8TH AVENUE SE

OLYMPIA, WA 98501

Award Period: 09/01/2021 – 09/30/2025

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of \$1,142,613 (see “Award Calculation” in Section I) to HEALTH CARE AUTHORITY in support of the above referenced project. This award is pursuant to the authority of Subparts I&III,B, Title XIX, PHS Act/45 CFR Part 96 and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Acceptance of this award including the “Terms and Conditions” is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

[REDACTED]

Grants Management Officer
Division of Grants Management

See additional information below

SECTION I – AWARD DATA – 1B09SM085912-01

FEDERAL FUNDS APPROVED: \$1,142,613

AMOUNT OF THIS ACTION (FEDERAL SHARE): \$1,142,613

CUMULATIVE AWARDS TO DATE: \$1,142,613

UNAWARDED BALANCE OF CURRENT YEAR’S FUNDS: \$0

Fiscal Information:

CFDA Number: 93.958

EIN: 1911412780A

Document Number: 21B3WACM HSC6

Fiscal Year: 2021

IC	CAN	01
SU	C96D210	\$1,142,613

PCC: CMHS / OC: 4115

SECTION II – PAYMENT/HOTLINE INFORMATION – 1B09SM085912-01

Payments under this award will be made available through the HHS Payment Management System (PMS). PMS is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). Inquiries regarding payment should be directed to: The Division of Payment Management System, PO Box 6021, Rockville, MD 20852, Help Desk Support – Telephone Number: 1-877-614-5533.

The HHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. The telephone number is: 1-800-HHS-TIPS (1-800-447-8477). The mailing address is: Office of Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington, DC 20201.

SECTION III – TERMS AND CONDITIONS – 1B09SM085912-01

STANDARD TERMS AND CONDITIONS

MHBG FY2021 ARP Mitigation

Remarks:

This Notice of Award (NoA) provides one-time funding made available by the American Rescue Plan Act of 2021, in accordance with H.R. 1319 – American Rescue Plan Act of 2021 the ARPA Act, 2021 [P.L. 117-2], available at <https://www.congress.gov/117/bills/hr1319/BILLS-117hr1319enr.pdf>.

This funding is available to expand dedicated testing and mitigation resources for people with mental health and substance use disorders. These funds will provide resources and flexibility for states to prevent, prepare for, and respond to the coronavirus disease 2019 (COVID-19) public health emergency and ensure the continuity of services to support individuals connected to the behavioral health system.

Required Plan Submission:

Due by October 1, 2021. COVID-19 Response Workplan and Overview

States must submit separate plans for expending these funds for both MHBG and SABG. States must explain the types of activities, including expenditures. Provide a detailed plan on how the state plan to implement COVID-19 testing and mitigation activities within the public mental health and or substance abuse system.

Due by October 1, 2021. COVID-19 Response Budget and Budget Justification

States must submit a budget and a budget justification capturing all expenses, including costs for administration at the state level and a plan to distribute it to providers, and subsequent reasons for the expenses in narrative format.

Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, upload the document (Microsoft Word or pdf) using the tab into the State Information Section, Chief Executive Officer's Funding Agreement – Certifications and Assurances/Letter Designating Signatory Authority. Please title this document "COVID Mitigation Funding Plan 2021(MH)" for MHBG and "COVID Mitigation Funding Plan 2021 (SA)" for SABG."

States must upload separate proposals based on Mental Health Block Grant and Substance Abuse Block Grant guidance into the WebBGAS system. Upon submission, SAMHSA will review the proposal to ensure it is complete and responsive. Proposals must be submitted to WebBGAS by Friday, October 1, 2021.

Standard Terms of Award:

1) Acceptance of the Terms of an Award

By drawing or otherwise obtaining funds from the HHS Payment Management System, the recipient acknowledges acceptance of the terms and conditions of the award and is obligated to perform in accordance with the requirements of the award. Once an award is accepted by a recipient, the contents of the Notice of Award (NoA) are binding on the recipient unless and until modified by a revised NoA signed by the GMO.

2) Official Form Designee

The States Chief Executive Officer, or authorized designee is considered the official form designee for this grant. The SAMHSA GMS and the MHBG Program Officer

must be notified immediately before any changes in this key position are made. Please note that individuals that are suspended or debarred are prohibited from serving on Federal grant awards.

3) Availability of Funds

Funds provided under this grant must be obligated and expended by September 30, 2025.

4) Fiscal and administrative requirements

This award is subject to the administrative requirements for HHS block grants under 45 CFR Part 96, Subpart C, and 45 CFR Part 75, as specified. Except for section 75.202 of Subpart C, and sections 75.351 through 75.353 of Subpart D, the requirements in Subpart C, Subpart D, and Subpart E do not apply to this program (reference 45 CFR Part 75 Subpart B, 75.101(d)).

Fiscal control and accounting procedures - Fiscal control and accounting procedures must be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant.

Audits - Grantees and subgrantees are responsible for obtaining audits in accordance with the Single Audit Act Amendments of 1996 (31 U.S.C. 7501-7507) and revised OMB Circular A-133, "Audits of State, Local Governments, and Non-Profit Organizations." The audits shall be made by an independent auditor in accordance with generally accepted Government auditing standards covering financial audits.

Financial settlement - The State must repay to the Department amounts found after audit resolution to have been expended improperly. In the event that repayment is not made voluntarily, the Department will undertake recovery.

5) Flow-down of requirements to sub-recipients

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients, in accordance with 45 CFR 75.351 75.353, Sub-recipient monitoring and management.

6) Executive Pay

The Consolidated Appropriations Act, 2021 (Public Law 116-260), signed into law on December 27, 2020 restricts the amount of direct salary to Executive Level II of the Federal Executive Pay scale. Effective January 3, 2021, the salary limitation for Executive Level II is \$199,300.

For awards issued prior to this change, if adequate funds are available in active awards, and if the salary cap increase is consistent with the institutional base salary, recipients may re-budget to accommodate the current Executive Level II salary level. However, no additional funds will be provided to these grant awards.

7) Marijuana Restriction

SAMHSA grant funds may not be used to purchase, prescribe, or provide marijuana or treatment using marijuana. See, e.g., 45 C.F.R. 75.300(a)

(requiring HHS to ensure that Federal funding is expended in full accordance with U.S. statutory and public policy requirements); 21 U.S.C. 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana).

8) Anti-discrimination

You must administer your project in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy). This includes taking reasonable steps to provide meaningful access to persons with limited English proficiency and providing programs that are accessible to and usable by persons with disabilities. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. See <https://www.hhs.gov/civil-rights/for-providers/provider-obligations/index.html> and <https://www.hhs.gov/civil-rights/for-individuals/nondiscrimination/index.html>.

- You must take reasonable steps to ensure that your project provides meaningful access to persons with limited English proficiency. For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see <https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html> and <https://www.lep.gov>.
- For information on your specific legal obligations for serving qualified individuals with disabilities, including providing program access, reasonable modifications, and taking appropriate steps to provide effective communication, see <http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html>.
- HHS funded health and education programs must be administered in an environment free of sexual harassment, see <https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html>.
- For guidance on administering your project in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see <https://www.hhs.gov/conscience/conscience-protections/index.html> and <https://www.hhs.gov/conscience/religious-freedom/index.html>.

9) System for Award Management (SAM)

This award is subject to requirement set forth in 2 CFR 25.110

Unless you are exempted from this requirement under 2 CFR 25.110, you, as the recipient, must maintain the currency of your information in the SAM, until you submit the final financial report required under this award or receive the final payment, whichever is later. This requires that you review and update the information at least annually after the initial registration, and more frequently if required by changes in your information or another award term. This requirement flows down to subrecipients and contractors under awards or subawards. SAM website: [System for Award Management \(SAM\)](#)

10) Federal Financial Accountability and Transparency Act (FFATA)

Reporting Subawards and Executive Compensation, 2 CFR, Appendix A to Part 170

The Federal Funding Accountability and Transparency Act (FFATA) was signed on September 26, 2006.

Unless you are exempt, you must report each action that obligates \$25,000 or more in Federal funds. The FFATA Subaward Reporting System (FSRS) is the reporting tool federal prime awardees (i.e. prime contractors and prime grants recipients) must use to capture and report subaward and executive compensation data regarding their first-tier subawards to meet the FFATA reporting requirements. Prime contract awardees must report against sub-contracts awarded. Prime grant awardees will report against sub-grants awarded. The sub-award information you enter in FSRS will display on USASpending.gov associated with the prime award. This furthers federal spending transparency.

You must report each obligating action to <http://www.fsrs.gov>

11) Mandatory Disclosures

Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the HHS Office of Inspector General (OIG), all information related to violations, or suspected violations, of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Subrecipients must disclose, in a timely manner, in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations, or suspected violations, of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Disclosures must be sent in writing to the awarding agency and to the HHS OIG at the following addresses:

U.S. Department of Health and Human Services Office of Inspector General

ATTN: Mandatory Grant Disclosures, Intake Coordinator 330 Independence Avenue,

SW, Cohen Building Room 5527 Washington, DC 20201

Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or email: MandatoryGranteeDisclosures@oig.hhs.gov

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371 remedies for noncompliance, including suspension or debarment (see 2 CFR parts 180 & 376 and 31 U.S.C. 3321).

12) The Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(G)), as amended, and 2 C.F.R. PART 175

The Trafficking Victims Protection Act of 2000 authorizes termination of financial assistance provided to a private entity, without penalty to the Federal government, if the recipient or subrecipient engages in certain activities related to trafficking in persons. SAMHSA may unilaterally terminate this award, without penalty, if a private entity recipient, or a private entity subrecipient, or their employees: a) Engage in severe forms of trafficking in persons during the period of time that the award is in effect; b) Procure a commercial sex act during the period of time that the award is in

effect; or, c) Use forced labor in the performance of the award or subawards under the award. The text of the full award term is available at 2 C.F.R. 175.15(b). See <http://www.gpo.gov/fdsys/pkg/CFR-2012-title2-vol1/pdf/CFR-2012-title2-vol1-sec175-15.pdf>.

13) Drug-Free Workplace Requirements

The Drug-Free Workplace Act of 1988 (41 U.S.C. 701 et seq.) requires that all organizations receiving grants from any Federal agency agree to maintain a drug-free workplace. When the AR signed the application, the AR agreed that the recipient will provide a drug-free workplace and will comply with the requirement to notify SAMHSA if an employee is convicted of violating a criminal drug statute. Failure to comply with these requirements may be cause for debarment. Government wide requirements for Drug-Free Workplace for Financial Assistance are found in 2 CFR part 182; HHS implementing regulations are set forth in 2 CFR part 382.400. All recipients of SAMHSA grant funds must comply with the requirements in Subpart B (or Subpart C if the recipient is an individual) of Part 382.

14) Lobbying

No funds provided under the attached Notice of Award (NoA) may be used by you or any sub-recipient under the grant to support lobbying activities to influence proposed or pending federal or state legislation or appropriations. The prohibition relates to the use of federal grant funds and is not intended to affect your right or that of any other organization, to petition Congress or any other level of government, through the use of other nonfederal resources. Reference 45 CFR Part 93.

15) Accessibility Provisions

Grant recipients of Federal financial assistance (FFA) from HHS must administer their programs in compliance with Federal civil rights law. This means that recipients of HHS funds must ensure equal access to their programs without regard to a person's race, color, national origin, disability, age, and in some circumstances, sex and religion. This includes ensuring your programs are accessible to persons with limited English proficiency. The HHS Office for Civil Rights also provides guidance on complying with civil rights laws enforced by HHS. Please see <http://www.hhs.gov/ocr/civilrights/understanding/section1557/index.html>. Recipients of FFA also have specific legal obligations for serving qualified individuals with disabilities. Please see <http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html>. Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under Federal civil rights laws at <https://www.hhs.gov/civil-rights/index.html> or call 1-800-368-1019 or TDD 1-800-537-7697. Also note that it is an HHS Departmental goal to ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations. For further guidance on providing culturally and linguistically appropriate services, recipients should review the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care at <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6>.

16) Audits

Non-Federal recipients that expend \$750,000 or more in federal awards during the recipient's fiscal year must obtain an audit conducted for that year in accordance with the provisions of 45 CFR 96.31.

Recipients are responsible for submitting their Single Audit Reports and the Data Collections Forms (SF-FAC) electronically to the to the Federal Audit Clearinghouse Visit disclaimer page (FAC) within the earlier of 30 days after receipt or nine months after the FY s end of the audit period. The FAC operates on behalf of the OMB.

For specific questions and information concerning the submission process: Visit the Federal Audit Clearinghouse at <https://harvester.census.gov/facweb> or Call FAC at the toll-free number: (800) 253-0696

Reporting Requirements:

Annual Report

Reporting on the ARPA funding is required. After the end of each fiscal year, a FY annual report is required on December 31, until the funds expire, and states must upload a narrative report including activities and expenditures. States must prepare and submit their respective reports utilizing WebBGAS. Your assigned MHBG Program Official will provide further guidance and additional submission information.

Failure to comply with these requirements may cause the initiation of enforcement actions that can culminate in discontinuation of MHBG grants.

Federal Financial Report (FFR)

The recipient is required to submit a Federal Financial Report (FFR) 90 days after the close of the performance period (project period). The SF-425 shall report total funds obligated and total funds expended by the grantee.

Effective January 1, 2021, award recipients are required to submit the SF-425 Federal Financial Report (FFR) via the Payment Management System (PMS). If the individual responsible for FFR submission does not already have an account with PMS, please [contact PMS](#) to obtain access.

Recipients must liquidate all obligations incurred under an award not later than ninety (90) days after the end of the award obligation and expenditure period (i.e., the project period) which also coincides with the due date for submission of the FINAL SF-425, *Federal Financial Report* (FFR). After ninety (90) days, letter of credit accounts are locked. SAMHSA does not approve extensions to the ninety (90) day post-award reconciliation/liquidation period. Therefore, recipients are expected to complete all work and reporting within the approved project period and the aforementioned 90-day post-award reconciliation/liquidation period. Recipients (late) withdrawal requests occurring after the aforementioned periods are denied. In rare instances, SAMHSA may approve an extension to submit a FINAL SF-425 FFR report, but this is *not* an extension of the 90-day post award reconciliation/liquidation period, but rather only an extension to submit the Final SF-425 report (FFR).

In accordance with the regulatory requirements provided at 45 CFR 75.113 and Appendix XII to 45 CFR Part 75, recipients that have currently active Federal grants, cooperative agreements, and procurement contracts with cumulative total value greater than \$10,000,000 must report and maintain information in the System for Award Management (SAM) about civil, criminal, and administrative proceedings in connection with the award or performance of a Federal award that reached final disposition within the most recent five-year period. The recipient must also make semiannual disclosures regarding such proceedings. Proceedings information will be made publicly available in the designated integrity and performance system (currently the Federal Awardee Performance and Integrity Information System (FAPIIS)). Full reporting requirements and procedures are found in Appendix XII to 45 CFR Part 75.

Staff Contacts:

[REDACTED], Program Official

Phone: 2 [REDACTED] Email: [REDACTED]

[REDACTED] Grants Specialist

Phone: [REDACTED] Email: [REDACTED] Fax: [REDACTED]

Exhibit J

**Recipient Information****1. Recipient Name**HEALTH CARE AUTHORITY
626 8TH AVENUE SE

OLYMPIA, WA 98501

2. Congressional District of Recipient

10

3. Payment System Identifier (ID)

1911412780A1

4. Employer Identification Number (EIN)

911412780

5. Data Universal Numbering System (DUNS)

007207571

6. Recipient's Unique Entity Identifier**7. Project Director or Principal Investigator**

[REDACTED]

[REDACTED]

8. Authorized Official

[REDACTED]

Federal Agency Information**9. Awarding Agency Contact Information**

[REDACTED]

Grants Management Specialist
Center for Substance Abuse Treatment

[REDACTED]

[REDACTED]

10. Program Official Contact Information

[REDACTED]

Center for Substance Abuse Treatment

[REDACTED]

Federal Award Information**11. Award Number**

1B08TI084617-01

12. Unique Federal Award Identification Number (FAIN)

B08TI084617

13. Statutory Authority

Subparts II&III,B, Title XIX, PHS Act/45 CFR Part96

14. Federal Award Project Title

Substance Abuse Prevention & Treatment Block Grant

15. Assistance Listing Number

93.959

16. Assistance Listing Program Title

Block Grants for Prevention and Treatment of Substance Abuse

17. Award Action Type

New Competing

18. Is the Award R&D?

No

Summary Federal Award Financial Information**19. Budget Period Start Date 09/01/2021 – End Date 09/30/2025****20. Total Amount of Federal Funds Obligated by this Action** \$1,076,243

20 a. Direct Cost Amount \$1,076,243

20 b. Indirect Cost Amount \$0

21. Authorized Carryover**22. Offset****23. Total Amount of Federal Funds Obligated this budget period** \$1,076,243**24. Total Approved Cost Sharing or Matching, where applicable** \$0**25. Total Federal and Non-Federal Approved this Budget Period** \$1,076,243**26. Project Period Start Date 09/01/2021 – End Date 09/30/2025****27. Total Amount of the Federal Award including Approved Cost** \$1,076,243

Sharing or Matching this Project Period

28. Authorized Treatment of Program Income

Additional Costs

29. Grants Management Officer - Signature

[REDACTED]

30. Remarks

Acceptance of this award, including the "Terms and Conditions," is acknowledged by the recipient when funds are drawn down or otherwise requested from the grant payment system.

Notice of Award



SABG
Department of Health and Human Services
Substance Abuse and Mental Health Services Administration

Issue Date: 08/10/2021

Center for Substance Abuse Treatment

Award Number: 1B08TI084617-01

FAIN: B08TI084617-01

Contact Person: [REDACTED]

Program: Substance Abuse Prevention & Treatment Block Grant

HEALTH CARE AUTHORITY
626 8TH AVENUE SE

OLYMPIA, WA 98501

Award Period: 09/01/2021 – 09/30/2025

Dear Grantee:

The Substance Abuse and Mental Health Services Administration hereby awards a grant in the amount of \$1,076,243 (see “Award Calculation” in Section I) to HEALTH CARE AUTHORITY in support of the above referenced project. This award is pursuant to the authority of Subparts II&III,B, Title XIX, PHS Act/45 CFR Part96 and is subject to the requirements of this statute and regulation and of other referenced, incorporated or attached terms and conditions.

Acceptance of this award including the “Terms and Conditions” is acknowledged by the grantee when funds are drawn down or otherwise obtained from the grant payment system.

If you have any questions about this award, please contact your Grants Management Specialist and your Government Project Officer listed in your terms and conditions.

Sincerely yours,

[REDACTED]

Grants Management Officer
Division of Grants Management

See additional information below

SECTION I – AWARD DATA – 1B08TI084617-01

FEDERAL FUNDS APPROVED: \$1,076,243

AMOUNT OF THIS ACTION (FEDERAL SHARE): \$1,076,243

CUMULATIVE AWARDS TO DATE: \$1,076,243

UNAWARDED BALANCE OF CURRENT YEAR’S FUNDS: \$0

Fiscal Information:

CFDA Number: 93.959

EIN: 1911412780A
1

Document 21B3WASAP

Number: TC6

Fiscal Year: 2021

IC	CAN	01
SU	C96D212	\$1,076,243

PCC: SAPT / OC: 4115

SECTION II – PAYMENT/HOTLINE INFORMATION – 1B08TI084617-01

Payments under this award will be made available through the HHS Payment Management System (PMS). PMS is a centralized grants payment and cash management system, operated by the HHS Program Support Center (PSC), Division of Payment Management (DPM). Inquiries regarding payment should be directed to: The Division of Payment Management System, PO Box 6021, Rockville, MD 20852, Help Desk Support – Telephone Number: 1-877-614-5533.

The HHS Inspector General maintains a toll-free hotline for receiving information concerning fraud, waste, or abuse under grants and cooperative agreements. The telephone number is: 1-800-HHS-TIPS (1-800-447-8477). The mailing address is: Office of Inspector General, Department of Health and Human Services, Attn: HOTLINE, 330 Independence Ave., SW, Washington, DC 20201.

SECTION III – TERMS AND CONDITIONS – 1B08TI084617-01

STANDARD TERMS AND CONDITIONS

SABG FY2021 ARP Mitigation

Remarks:

This Notice of Award (NoA) provides one-time funding made available by the American Rescue Plan Act of 2021, in accordance with H.R. 1319 – American Rescue Plan Act of 2021 the ARPA Act, 2021 [P.L. 117-2], available at <https://www.congress.gov/117/bills/hr1319/BILLS-117hr1319enr.pdf>.

This funding is available to expand dedicated testing and mitigation resources for people with mental health and substance use disorders. These funds will provide resources and flexibility for states to prevent, prepare for, and respond to the coronavirus disease 2019 (COVID-19) public health emergency and ensure the continuity of services to support individuals connected to the behavioral health system.

Required Plan Submission:

Due by October 1, 2021. COVID-19 Response Workplan and Overview

States must submit separate plans for expending these funds for both MHBG and SABG. States must explain the types of activities, including expenditures. Provide a detailed plan on how the state plan to implement COVID-19 testing and mitigation activities within the public mental health and or substance abuse system.

Due by October 1, 2021. COVID-19 Response Budget and Budget Justification

States must submit a budget and a budget justification capturing all expenses, including costs for administration at the state level and a plan to distribute it to providers, and subsequent reasons for the expenses in narrative format.

Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, upload the document (Microsoft Word or pdf) using the tab into the State Information Section, Chief Executive Officer's Funding Agreement – Certifications and Assurances/Letter Designating Signatory Authority. Please title this document "COVID Mitigation Funding Plan 2021(MH)" for MHBG and "COVID Mitigation Funding Plan 2021 (SA)" for SABG."

States must upload separate proposals based on Mental Health Block Grant and Substance Abuse Block Grant guidance into the WebBGAS system. Upon submission, SAMHSA will review the proposal to ensure it is complete and responsive. Proposals must be submitted to WebBGAS by Friday, October 1, 2021.

Standard Terms of Award:

1) Acceptance of the Terms of an Award

By drawing or otherwise obtaining funds from the HHS Payment Management System, the recipient acknowledges acceptance of the terms and conditions of the award and is obligated to perform in accordance with the requirements of the award. Once an award is accepted by a recipient, the contents of the Notice of Award (NoA) are binding on the recipient unless and until modified by a revised NoA signed by the GMO.

2) Official Form Designee

The States Chief Executive Officer, or authorized designee is considered the official form designee for this grant. The SAMHSA GMS and the SABG Program Officer

must be notified immediately before any changes in this key position are made. Please note that individuals that are suspended or debarred are prohibited from serving on Federal grant awards.

3) Availability of Funds

Funds provided under this grant must be obligated and expended by September 30, 2025.

4) Fiscal and administrative requirements

This award is subject to the administrative requirements for HHS block grants under 45 CFR Part 96, Subpart C, and 45 CFR Part 75, as specified. Except for section 75.202 of Subpart C, and sections 75.351 through 75.353 of Subpart D, the requirements in Subpart C, Subpart D, and Subpart E do not apply to this program (reference 45 CFR Part 75 Subpart B, 75.101(d)).

Fiscal control and accounting procedures - Fiscal control and accounting procedures must be sufficient to (a) permit preparation of reports required by the statute authorizing the block grant and (b) permit the tracing of funds to a level of expenditure adequate to establish that such funds have not been used in violation of the restrictions and prohibitions of the statute authorizing the block grant.

Audits - Grantees and subgrantees are responsible for obtaining audits in accordance with the Single Audit Act Amendments of 1996 (31 U.S.C. 7501-7507) and revised OMB Circular A-133, "Audits of State, Local Governments, and Non-Profit Organizations." The audits shall be made by an independent auditor in accordance with generally accepted Government auditing standards covering financial audits.

Financial settlement - The State must repay to the Department amounts found after audit resolution to have been expended improperly. In the event that repayment is not made voluntarily, the Department will undertake recovery.

5) Flow-down of requirements to sub-recipients

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients, in accordance with 45 CFR 75.351 75.353, Sub-recipient monitoring and management.

6) Executive Pay

The Consolidated Appropriations Act, 2021 (Public Law 116-260), signed into law on December 27, 2020 restricts the amount of direct salary to Executive Level II of the Federal Executive Pay scale. Effective January 3, 2021, the salary limitation for Executive Level II is \$199,300.

For awards issued prior to this change, if adequate funds are available in active awards, and if the salary cap increase is consistent with the institutional base salary, recipients may re-budget to accommodate the current Executive Level II salary level. However, no additional funds will be provided to these grant awards.

7) Marijuana Restriction

SAMHSA grant funds may not be used to purchase, prescribe, or provide

marijuana or treatment using marijuana. See, e.g., 45 C.F.R. 75.300(a) (requiring HHS to ensure that Federal funding is expended in full accordance with U.S. statutory and public policy requirements); 21 U.S.C. 812(c)(10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana).

8) Anti-discrimination

You must administer your project in compliance with federal civil rights laws that prohibit discrimination on the basis of race, color, national origin, disability, age and, in some circumstances, religion, conscience, and sex (including gender identity, sexual orientation, and pregnancy). This includes taking reasonable steps to provide meaningful access to persons with limited English proficiency and providing programs that are accessible to and usable by persons with disabilities. The HHS Office for Civil Rights provides guidance on complying with civil rights laws enforced by HHS. See <https://www.hhs.gov/civil-rights/for-providers/provider-obligations/index.html> and <https://www.hhs.gov/civil-rights/for-individuals/nondiscrimination/index.html>.

- You must take reasonable steps to ensure that your project provides meaningful access to persons with limited English proficiency. For guidance on meeting your legal obligation to take reasonable steps to ensure meaningful access to your programs or activities by limited English proficient individuals, see <https://www.hhs.gov/civil-rights/for-individuals/special-topics/limited-english-proficiency/fact-sheet-guidance/index.html> and <https://www.lep.gov>.
- For information on your specific legal obligations for serving qualified individuals with disabilities, including providing program access, reasonable modifications, and taking appropriate steps to provide effective communication, see <http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html>.
- HHS funded health and education programs must be administered in an environment free of sexual harassment, see <https://www.hhs.gov/civil-rights/for-individuals/sex-discrimination/index.html>.
- For guidance on administering your project in compliance with applicable federal religious nondiscrimination laws and applicable federal conscience protection and associated anti-discrimination laws, see <https://www.hhs.gov/conscience/conscience-protections/index.html> and <https://www.hhs.gov/conscience/religious-freedom/index.html>.

9) System for Award Management (SAM)

This award is subject to requirement set forth in 2 CFR 25.110

Unless you are exempted from this requirement under 2 CFR 25.110, you, as the recipient, must maintain the currency of your information in the SAM, until you submit the final financial report required under this award or receive the final payment, whichever is later. This requires that you review and update the information at least annually after the initial registration, and more frequently if required by changes in your information or another award term. This requirement flows down to subrecipients and contractors under awards or subawards. SAM website: [System for Award Management \(SAM\)](#)

10) Federal Financial Accountability and Transparency Act (FFATA)

Reporting Subawards and Executive Compensation, 2 CFR, Appendix A to Part 170

The Federal Funding Accountability and Transparency Act (FFATA) was signed on September 26, 2006.

Unless you are exempt, you must report each action that obligates \$25,000 or more in Federal funds. The FFATA Subaward Reporting System (FSRS) is the reporting tool federal prime awardees (i.e. prime contractors and prime grants recipients) must use to capture and report subaward and executive compensation data regarding their first-tier subawards to meet the FFATA reporting requirements. Prime contract awardees must report against sub-contracts awarded. Prime grant awardees will report against sub-grants awarded. The sub-award information you enter in FSRS will display on USASpending.gov associated with the prime award. This furthers federal spending transparency.

You must report each obligating action to <http://www.fsr.gov>

11) Mandatory Disclosures

Consistent with 45 CFR 75.113, applicants and recipients must disclose in a timely manner, in writing to the HHS Office of Inspector General (OIG), all information related to violations, or suspected violations, of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Subrecipients must disclose, in a timely manner, in writing to the prime recipient (pass through entity) and the HHS OIG, all information related to violations, or suspected violations, of Federal criminal law involving fraud, bribery, or gratuity violations potentially affecting the Federal award. Disclosures must be sent in writing to the awarding agency and to the HHS OIG at the following addresses:

U.S. Department of Health and Human Services Office of Inspector General

ATTN: Mandatory Grant Disclosures, Intake Coordinator 330 Independence Avenue,

SW, Cohen Building Room 5527 Washington, DC 20201

Fax: (202) 205-0604 (Include "Mandatory Grant Disclosures" in subject line) or email: MandatoryGranteeDisclosures@oig.hhs.gov

Failure to make required disclosures can result in any of the remedies described in 45 CFR 75.371 remedies for noncompliance, including suspension or debarment (see 2 CFR parts 180 & 376 and 31 U.S.C. 3321).

12) The Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(G)), as amended, and 2 C.F.R. PART 175

The Trafficking Victims Protection Act of 2000 authorizes termination of financial assistance provided to a private entity, without penalty to the Federal government, if the recipient or subrecipient engages in certain activities related to trafficking in persons. SAMHSA may unilaterally terminate this award, without penalty, if a private entity recipient, or a private entity subrecipient, or their employees: a) Engage in severe forms of trafficking in persons during the period of time that the award is in

effect; b) Procure a commercial sex act during the period of time that the award is in effect; or, c) Use forced labor in the performance of the award or subawards under the award. The text of the full award term is available at 2 C.F.R. 175.15(b). See <http://www.gpo.gov/fdsys/pkg/CFR-2012-title2-vol1/pdf/CFR-2012-title2-vol1-sec175-15.pdf>.

13) Drug-Free Workplace Requirements

The Drug-Free Workplace Act of 1988 (41 U.S.C. 701 et seq.) requires that all organizations receiving grants from any Federal agency agree to maintain a drug-free workplace. When the AR signed the application, the AR agreed that the recipient will provide a drug-free workplace and will comply with the requirement to notify SAMHSA if an employee is convicted of violating a criminal drug statute. Failure to comply with these requirements may be cause for debarment. Government wide requirements for Drug-Free Workplace for Financial Assistance are found in 2 CFR part 182; HHS implementing regulations are set forth in 2 CFR part 382.400. All recipients of SAMHSA grant funds must comply with the requirements in Subpart B (or Subpart C if the recipient is an individual) of Part 382.

14) Lobbying

No funds provided under the attached Notice of Award (NoA) may be used by you or any sub-recipient under the grant to support lobbying activities to influence proposed or pending federal or state legislation or appropriations. The prohibition relates to the use of federal grant funds and is not intended to affect your right or that of any other organization, to petition Congress or any other level of government, through the use of other nonfederal resources. Reference 45 CFR Part 93.

15) Accessibility Provisions

Grant recipients of Federal financial assistance (FFA) from HHS must administer their programs in compliance with Federal civil rights law. This means that recipients of HHS funds must ensure equal access to their programs without regard to a person's race, color, national origin, disability, age, and in some circumstances, sex and religion. This includes ensuring your programs are accessible to persons with limited English proficiency. The HHS Office for Civil Rights also provides guidance on complying with civil rights laws enforced by HHS. Please see <http://www.hhs.gov/ocr/civilrights/understanding/section1557/index.html>. Recipients of FFA also have specific legal obligations for serving qualified individuals with disabilities. Please see <http://www.hhs.gov/ocr/civilrights/understanding/disability/index.html>. Please contact the HHS Office for Civil Rights for more information about obligations and prohibitions under Federal civil rights laws at <https://www.hhs.gov/civil-rights/index.html> or call 1-800-368-1019 or TDD 1-800-537-7697. Also note that it is an HHS Departmental goal to ensure access to quality, culturally competent care, including long-term services and supports, for vulnerable populations. For further guidance on providing culturally and linguistically appropriate services, recipients should review the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care at <https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=1&lvlid=6>.

16) Audits

Non-Federal recipients that expend \$750,000 or more in federal awards during the recipient's fiscal year must obtain an audit conducted for that year in accordance with the provisions of 45 CFR 96.31.

Recipients are responsible for submitting their Single Audit Reports and the Data Collections Forms (SF-FAC) electronically to the Federal Audit Clearinghouse Visit disclaimer page (FAC) within the earlier of 30 days after receipt or nine months after the FY s end of the audit period. The FAC operates on behalf of the OMB.

For specific questions and information concerning the submission process: Visit the Federal Audit Clearinghouse at <https://harvester.census.gov/facweb> or Call FAC at the toll-free number: (800) 253-0696

Reporting Requirements:

Annual Report

Reporting on the ARPA funding is required. After the end of each fiscal year, a FY annual report is required on December 31, until the funds expire, and states must upload a narrative report including activities and expenditures. States must prepare and submit their respective reports utilizing WebBGAS. Your assigned SABG Program Official will provide further guidance and additional submission information.

Failure to comply with these requirements may cause the initiation of enforcement actions that can culminate in discontinuation of SABG grants.

Federal Financial Report (FFR)

The recipient is required to submit a Federal Financial Report (FFR) 90 days after the close of the performance period (project period). The SF-425 shall report total funds obligated and total funds expended by the grantee.

Effective January 1, 2021, award recipients are required to submit the SF-425 Federal Financial Report (FFR) via the Payment Management System (PMS). If the individual responsible for FFR submission does not already have an account with PMS, please [contact PMS](#) to obtain access.

Recipients must liquidate all obligations incurred under an award not later than ninety (90) days after the end of the award obligation and expenditure period (i.e., the project period) which also coincides with the due date for submission of the FINAL SF-425, *Federal Financial Report* (FFR). After ninety (90) days, letter of credit accounts are locked. SAMHSA does not approve extensions to the ninety (90) day post-award reconciliation/liquidation period. Therefore, recipients are expected to complete all work and reporting within the approved project period and the aforementioned 90-day post-award reconciliation/liquidation period. Recipients (late) withdrawal requests occurring after the aforementioned periods are denied. In rare instances, SAMHSA may approve an extension to submit a FINAL SF-425 FFR report, but this is *not* an extension of the 90-day post award reconciliation/liquidation period, but rather only an extension to submit the Final SF-425 report (FFR).

In accordance with the regulatory requirements provided at 45 CFR 75.113 and Appendix XII to 45 CFR Part 75, recipients that have currently active Federal grants, cooperative agreements, and procurement contracts with cumulative total value greater than \$10,000,000 must report and maintain information in the System for Award Management (SAM) about civil, criminal, and administrative proceedings in connection with the award or performance of a Federal award that reached final disposition within the most recent five-year period. The recipient must also make semiannual disclosures regarding such proceedings. Proceedings information will be made publicly available in the designated integrity and performance system (currently the Federal Awardee Performance and Integrity Information System (FAPIIS)). Full reporting requirements and procedures are found in Appendix XII to 45 CFR Part 75.

Staff Contacts:

[REDACTED], Program Official

Phone: [REDACTED] **Email:** [REDACTED]

[REDACTED], Grants Specialist

Phone: [REDACTED] **Email:** [REDACTED] **Fax:** [REDACTED]

Exhibit K

From: [REDACTED]@samhsa.hhs.gov
To: [REDACTED]
Cc: [REDACTED]
Subject: B08T1084617: Termination Notice for COVID-19 Grant Funding
Date: Monday, March 24, 2025 2:38:46 PM

External Email

Dear Single State Authority Director and State Mental Health Commissioner,

During the COVID-19 pandemic, the Substance Abuse Mental Health Services Administration (SAMHSA) awarded several pandemic-related grants including the funded [Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 \(H.R.6074\) \(CRRSA\)](#) which provided funds to respond to the coronavirus outbreak and the [American Rescue Plan \(ARP\) Act of 2021\(H.R. 1319\)](#) which provided additional relief to address the continued impact of COVID-19 (i.e., coronavirus disease 2019) on the economy, public health, state and local governments, individuals, and businesses.

On April 10, 2023, President Biden signed [PL 188-3](#) terminating the national emergency concerning the COVID-19 pandemic. Consistent with the President's Executive Order 14222, Implementing the President's "Department of Government Efficiency" Cost Efficiency Initiative requiring a comprehensive review of SAMHSA grants, and where appropriate and consistent with applicable law, terminate such grants to reduce the overall Federal spending **this grant is being terminated effective March 24, 2025**. These grants were issued for a limited purpose: To ameliorate the effects of the pandemic. The end of the pandemic provides cause to terminate COVID-related grants. Now that the pandemic is over, the grants are no longer necessary.

In accordance with [45 CFR 96.30 \(4\)](#), block grant award recipients are required to provide a Financial Status Report (FFR) within 90 days of the close of the applicable statutory grant period. Recipients must liquidate all obligations incurred under an award after the end of the award obligation and expenditure period (i.e., the project period) which also coincides with the due date for submission of the FINAL SF-425, Federal Financial Report (FFR). Reimbursements after termination are allowable if it results from obligations which were properly incurred before the effective date of this termination.

Recipients are expected to complete all work immediately and the reconciliation/liquidation process no later than 90-days after the award period end date.

The related Payment Management System accounts will be restricted from drawdown going further. Additional information will be provided in the revised Notice of Award that will be issued to initiate the award period end date.

[[Correspondence Token: 9b894e49-9d8a-4663-bc6e-0e095a11b0c6]] -- Do not delete or change this line. --

Please "Reply All" and do NOT delete eracorrespondence@nih.gov from the list of recipients or change the subject line.

Exhibit L

From: [REDACTED]@samhsa.hhs.gov
To: [REDACTED]
Cc: [REDACTED]
Subject: B09SM085912: Termination Notice for COVID-19 Grant Funding
Date: Monday, March 24, 2025 2:50:02 PM

External Email

Dear Single State Authority Director and State Mental Health Commissioner,

During the COVID-19 pandemic, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded several pandemic-related grants including the funded [Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020](#) (H.R.6074) (CRRSA) which provided funds to respond to the coronavirus outbreak and the [American Rescue Plan](#) (ARP) Act of 2021(H.R. 1319) which provided additional relief to address the continued impact of COVID-19 (i.e., coronavirus disease 2019) on the economy, public health, state and local governments, individuals, and businesses.

On April 10, 2023, President Biden signed [PL 188-3](#) terminating the national emergency concerning the COVID-19 pandemic. Consistent with the President's Executive Order 14222, Implementing the President's "Department of Government Efficiency" Cost Efficiency Initiative requiring a comprehensive review of SAMHSA grants, and where appropriate and consistent with applicable law, terminate such grants to reduce the overall Federal spending **this grant is being terminated effective March 24, 2025**. These grants were issued for a limited purpose: To ameliorate the effects of the pandemic. The end of the pandemic provides cause to terminate COVID-related grants. Now that the pandemic is over, the grants are no longer necessary.

In accordance with [45 CFR 96.30 \(4\)](#), block grant award recipients are required to provide a Financial Status Report (FFR) within 90 days of the close of the applicable statutory grant period. Recipients must liquidate all obligations incurred under an award after the end of the award obligation and expenditure period (i.e., the project period) which also coincides with the due date for submission of the FINAL SF-425, Federal Financial Report (FFR). Reimbursements after termination are allowable if it results from obligations which were properly incurred before the effective date of this termination.

Recipients are expected to complete all work immediately and the reconciliation/liquidation process no later than 90-days after the award period end date.

The related Payment Management System accounts will be restricted from drawdown going further. Additional information will be provided in the revised Notice of Award that will be issued to initiate the award period end date.

[[Correspondence Token: af3f52e4-9992-4421-bd8b-898fdcd83523]] -- Do not delete or change this line. --

Please "Reply All" and do NOT delete eracorrespondence@nih.gov from the list of recipients or change the subject line.

Exhibit M

From: [REDACTED] ([SAMHSA/OFR](#))
To: [REDACTED]
Cc: [REDACTED]
Subject: B08TI084617: Block Grant Termination Notice for COVID-19 Awards (CRRSA and ARP)
Date: Friday, March 28, 2025 9:42:51 AM
Attachments: [95-8648 BG hearing procedure.pdf](#)

External Email

Dear Single State Authority Director and State Mental Health Commissioner,
You received notification on March 24, 2025, that your award was being terminated. This notice replaces and supersedes the previous notice.

During the COVID-19 pandemic, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded several pandemic-related grants funded by the [Coronavirus Response and Relief Supplemental Appropriations Act](#) (CRRSA) which provided funds to respond to the coronavirus outbreak and the [American Rescue Plan](#) (ARP) Act which provided additional relief to address the continued impact of COVID-19.

The termination of this award is for cause. The block grant provisions at [42 U.S.C. §300x-55](#) permit termination if the state "has materially failed to comply with the agreements or other conditions required for the receipt of a grant under the program involved." The end of the pandemic provides cause to terminate COVID-related grants and cooperative agreements. These grants and cooperative agreements were issued for a limited purpose: to ameliorate the effects of the pandemic. Now that the pandemic is over, the grants and cooperative agreements are no longer necessary as their limited purpose has run out. Termination of this award is effective as of 11:59PM EDT, March 24, 2025.

In accordance with [45 CFR 96.30 \(4\)](#), block grant award recipients are required to provide a Financial Status Report (FFR) no later than 90 calendar days after March 24, 2025. Recipients must liquidate all obligations incurred under an award no later than 90 calendar days after March 24, 2025, which also coincides with the due date for submission of the FINAL SF-425, Federal Financial Report (FFR). Reimbursements after termination are allowable if the reimbursements result from obligations which were properly incurred on or before March 24, 2025.

Recipients are expected to cease all activities immediately and complete the reconciliation/liquidation process no later than 90 calendar days after the termination effective date.

Opportunity for Hearing:

Per the enclosed hearing procedures, block grant recipients may request a hearing to dispute this decision by submitting a written notice to the Substance Abuse and Mental Health Services Administration (SAMHSA) requesting a hearing within 15 calendar days of the date of this notice to: SAMHSAgrants@samhsa.hhs.gov. The request for a hearing must include a copy of this termination notice and a brief statement of why this decision should not be upheld.

Enclosure

[[Correspondence Token: 4a588c06-8180-4c17-9f99-07f8eb4c23a8]] -- Do not delete or change this line. --

Please 'Reply All' and do NOT delete eracorrespondence@nih.gov from the list of recipients or change the subject line.

Exhibit N

From: [REDACTED]
To: [REDACTED]
Cc: [REDACTED]
Subject: B09SM085912: Block Grant Termination Notice for COVID-19 Awards (CRRSA and ARP)
Date: Friday, March 28, 2025 9:37:27 AM
Attachments: [95-8648 BG hearing procedure.pdf](#)

External Email

Dear Single State Authority Director and State Mental Health Commissioner,
You received notification on March 24, 2025, that your award was being terminated. This notice replaces and supersedes the previous notice.

During the COVID-19 pandemic, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded several pandemic-related grants funded by the [Coronavirus Response and Relief Supplemental Appropriations Act \(CRRSA\)](#) which provided funds to respond to the coronavirus outbreak and the [American Rescue Plan \(ARP\)](#) Act which provided additional relief to address the continued impact of COVID-19.

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In accordance with [45 CFR 96.30 \(4\)](#), block grant award recipients are required to provide a Financial Status Report (FFR) no later than 90 calendar days after March 24, 2025. Recipients must liquidate all obligations incurred under an award no later than 90 calendar days after March 24, 2025, which also coincides with the due date for submission of the FINAL SF-425, Federal Financial Report (FFR). Reimbursements after termination are allowable if the reimbursements result from obligations which were properly incurred on or before March 24, 2025.

Recipients are expected to cease all activities immediately and complete the reconciliation/liquidation process no later than 90 calendar days after the termination effective date.

Opportunity for Hearing:

Per the enclosed hearing procedures, block grant recipients may request a hearing to dispute this decision by submitting a written notice to the Substance Abuse and Mental Health Services Administration (SAMHSA) requesting a hearing within 15 calendar days of the date of this notice to: SAMHSAgrants@samhsa.hhs.gov. The request for a hearing must include a copy of this termination notice and a brief statement of why this decision should not be upheld.

Enclosure

[[Correspondence Token: 39230b21-12a2-41eb-8f83-aa85cc931873]] -- Do not delete or change this line. --

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